

Northumbria Research Link

Citation: Parker, Christopher (2017) Lived experiences of 'choice', control' and 'success' in housing first. Doctoral thesis, Northumbria University.

This version was downloaded from Northumbria Research Link:
<http://nrl.northumbria.ac.uk/id/eprint/36205/>

Northumbria University has developed Northumbria Research Link (NRL) to enable users to access the University's research output. Copyright © and moral rights for items on NRL are retained by the individual author(s) and/or other copyright owners. Single copies of full items can be reproduced, displayed or performed, and given to third parties in any format or medium for personal research or study, educational, or not-for-profit purposes without prior permission or charge, provided the authors, title and full bibliographic details are given, as well as a hyperlink and/or URL to the original metadata page. The content must not be changed in any way. Full items must not be sold commercially in any format or medium without formal permission of the copyright holder. The full policy is available online: <http://nrl.northumbria.ac.uk/policies.html>

Lived Experiences of ‘Choice’, ‘Control’, and ‘Success’ in Housing First

Christopher N Parker

A thesis submitted in partial fulfilment of
the requirement for the award for the
degree of Doctor of Philosophy at the
University of Northumbria at Newcastle

Research undertaken in the Faculty of
Arts, Design and Social Sciences

2017

Volume 1 of 2

Abstract

This thesis is concerned with notions of 'choice and control' in the Housing First model, and how these contribute to successful outcomes for multiply excluded homeless (MEH) adults.

Housing First aims to overcome homelessness and prevent further exclusion by offering immediate, independent accommodation in the community. In doing so, the model seeks to provide a foundation for client centred support, guided by client choice, which enables recovery from the 'multiple and complex' needs most MEH adults face.

The majority of Housing First literature has focused on the model's very positive housing related outcomes. However, longer-term outcomes related to recovery and desistance have been less clear.

The thesis centres on a qualitative, longitudinal evaluation of a Housing First service in Newcastle-upon-Tyne. Housing First is relatively new in England, and there has been only limited evaluation of the model's effectiveness in this context. This study contributed to this gap in knowledge by following 18 MEH adults over 16 months in their Housing First tenancy. A mixed methods design was employed to explore participants' ability to utilise the 'choice and control' offered in Housing First to achieve outcomes related to recovery and desistance. The methodology was informed by a situational approach that places the participant at the centre of analysis and explores both the personal and environmental factors that influence their choices, and resulting actions.

Findings demonstrated the importance of participants' biographies in determining their 'starting point' in Housing First, and their ability to make choices towards recovery and desistance. A key output of the study was a typology based on participants' life histories that was predictive of their trajectories towards recovery and desistance. In general terms, those with less complex life histories were more able to take advantage of the foundation provided by Housing First.

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas, and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved.

Approval has been sought and granted by the Faculty Ethics Committee on 22/05/2015

I declare that the Word Count of this Thesis is 84,967 words

Name: Christopher N Parker

Signature: *Chris Parker*

Date: 10/08/2017

Acknowledgements

First and foremost I must acknowledge each of the 18 participants who agreed to share their life histories and experiences of Housing First with me. To say I was humbled by those conversations is an understatement. I am tremendously grateful to them for opening up to me and discussing some tremendously challenging experiences. I hope that I have done them justice by contributing to positive change in the services which support them.

I must also thank each of my professional stakeholder participants for their insightful and honest perspectives throughout the study. Particular thanks must go to the case managers of the 'Multiple Exclusion' service for their unending support and positive attitude to my research. At no point did they see my presence as a burden. Instead, they made me feel welcome from the very start, taking time out of their busy and challenging work schedules to provide essential support to this study. This leads me to thank Newcastle City Council and Changing Lives for allowing me to evaluate the service. Both organisations approached the research with an open attitude, seeking to understand ways of improving their provision for the individual's they support.

I must offer a huge thanks to each of my academic mentors. Firstly, Dr. Mike Barke, my undergraduate dissertation tutor. I did not even consider myself capable of PhD study before I met him. Secondly, my PhD supervisors; Dr. Jamie Harding, Dr. Darryl Humble, and Dr. Wendy Dyer for their clear and supportive feedback throughout my research. Our discussions were always stimulating, challenging, interesting, and above all enjoyable. A special thanks must go my principal supervisor Dr. Jamie Harding who has been a fantastic mentor in every sense of the word, being concerned not only with my academic endeavours, but with me as a person. I simply could not have wished for better support through this process.

To my dad, who supported me without question in all of my endeavours and amongst everything else gave me the humility required to understand the people at the centre of this thesis without judgement. I wish you could have seen me undertake this PhD. To my mam, who kept me grounded and reminded me that life is bigger than my PhD. I have no doubt that my social conscience came from you (and grandad Joe) and I would never have had the drive to undertake this journey if I had not had you as my mother. To Townes Van Zandt and Guy Clark, your music helped me understand the lives of these participants as much as any academic source.

Finally, I must thank my partner, Anna who has lived this PhD with me. Our relationship has offered me the emotional foundation required to pursue this piece of research.

Contents

1: Introduction	13
1.1: Research Objectives	15
2: Housing First: Origins, Philosophy, Proliferation, and Outcomes.....	22
2.1: Introduction	22
2.2: Treatment First Ideology	23
2.3: The Complex and the Excluded	26
2.4: Supportive Housing	27
2.5: Pathways Housing First.....	28
2.6: Proliferation of the model.....	32
2.6.1: US Proliferation and Policy Context.....	32
2.6.2: International Proliferation and Variation	34
2.6.3: Beyond Housing: Recovery in Housing First	41
2.7: Housing First Principles	43
2.7.1: Immediate, Independent, Scattered Site Housing	44
2.7.2: Harm Reduction Approach to Substance Use	46
2.7.3: Open Ended Support.....	47
2.7.4: Separation of Housing and Treatment	48
2.8 - UK and England	53
2.8.1: English Policy Context.....	55
2.8.2 - Housing First Newcastle	57
2.9: Conclusion	62
3: Understanding ‘Choice’ and ‘Success’ for MEH adults: A Situational Approach .	65
3.1: Introduction	65
3.2: Choices of MEH Adults in Housing First and Beyond	66
3.3: From Rational, Optimising Actor to Bounded Rationality.....	69
3.4: Contextualised Rational Action	71
3.5: Situational Action Theory	73
3.5.1: The Perception – Choice Process	80
3.5.2: The Multiply Excluded Homeless Actor (Person).....	81
3.5.3: Environments of Exclusion and Disadvantage (Setting)	91
3.6: The Importance of Time	100
3.7: Conclusion	102
4: Methodology	106
4.1: Introduction	106
4.2: Research Design	107

4.2.1: Research Aims and Literature Review	107
4.2.2: Ontological and Epistemological Considerations	108
4.2.3: Qualitative Longitudinal Approach.....	110
4.2.4: Mixed Method with Qualitative Bias	112
4.3: Sampling and Recruitment	124
4.3.1: Sampling Strategy	124
4.3.2: Participant Recruitment	126
4.4: Data Collection and Analysis	129
4.4.1: Wave 1	130
4.4.2: Wave 2	136
4.4.3: Wave 3	143
4.5: Final Summative Analysis	145
4.5.1: Outcome Measurement and Trajectory Categorisation	146
4.5.2: Life History Categorisations	148
4.5.3: Environmental factors influencing the capacity for choice and control for each client.....	149
4.5.4: Cross Case Analyses of the Three Data Sets	152
4.6: Ethical Reflections	154
4.6.1: Consent	154
4.6.2: Confidentiality and presenting case history data.....	155
4.6.3: 'Researching Violence, Trauma and Pain' – Reflections on the emotional impact of researching adverse life conditions	156
4.7: Conclusion	158
5: Establishing and Measuring 'Success': Outcome Priorities and Trajectories	161
5.1: Introduction	161
5.2: Personal Priorities	162
5.2.1: The nature of participants' outcome priorities	163
5.2.2: Personal Priorities vs. Service Outcomes	166
5.2.3: Mutual Dependency of All Outcomes.....	169
5.2.4: Performativity and Priorities	171
5.3: Trajectories.....	172
5.3.1: Participants' Outcome Trajectories.....	172
5.4: 'Success' Across Individual Outcome Domains	188
5.4.1: Housing Retention and Stability	188
5.4.2: 'Home Building' and Housing as Foundation	190
5.4.3: Housing First, What After?	195
5.4.4: Substance Misuse	195
5.4.5: Mental Health and Wellbeing	197

5.4.6: ‘Street Culture’ and Offending	200
5.4.7: Community Integration.....	202
5.4.8: Meaningful Activities	205
5.5: Conclusion	207
6: Personal Analysis of Capacity for ‘Choice and Control’	209
6.1: Introduction	209
6.2: General Sense of Choice	211
6.2.2: Perceived Choice over Housing	211
6.2.3: Perceived Choice over Support.....	213
6.2.4: Perceived Choice over Behaviour	216
6.2.5: Conclusion on Perceived Choice	218
6.3: A Typology of Participants ‘Needs’ and ‘Capabilities’	219
6.3.1: ‘Middle Aged Desisters’	227
6.3.2: ‘Young and Excluded’	233
6.3.3: ‘Ageing Drinkers’	239
6.3.4: ‘Severely Disadvantaged’	247
6.4: Typology vs. Trajectories in Housing First	252
6.5: Conclusion	254
7: Environmental Analysis of the Capacity for ‘Choice and Control’	256
7.1: Introduction	256
7.2: Commonalities in Environmental Factors	257
7.2.1: Common factors influencing choice over access to housing	257
7.2.2: Institutional and Professional Support	264
7.2.3: Local Social Networks.....	269
7.3: Differences in Environmental Factors by ‘Type’	270
7.3.1: ‘Middle Aged Desisters’	270
7.3.2: ‘Young and Excluded’	279
7.3.3: ‘Ageing Drinkers’	284
7.3.4: ‘Severely Disadvantaged’	293
7.4: Conclusion	298
8: Concluding Discussion	301
8.1: Limitations of the Study	303
8.2: Delivering Housing First in England: Negotiating a Culture Change and going beyond Housing Retention.....	304
8.3: Success: Housing First, What After?	307
8.2.1: What did clients want?	308
8.2.2: Trajectories of Change	310
8.4: Situational Inequalities in using ‘Choice and Control’ to achieve ‘Success’	313

8.4.1: The Importance of Biographical Context	314
8.4.2: Sourcing Housing from the PRS	318
8.4.3: The Orientation of Local Social Networks	319
8.4.4: The limits of a 'Signposting' Model	322
8.5: Choice and Control: Humane, but effective?	325

Figures and Tables

Figures

2.1: Allocation of Support According to Need in Housing First	30
3.1: Theoretical Framework of a ‘Situational Approach’ to Explaining Decision Making Processes	78
3.2: Relationship between experiences and decisions	80
4.1: Snapshot of ‘Jimmy’s’ Situational Map in Housing First	142
4.2: Example of Framework Analysis for ‘Setting based facilitators of Choice and Control’	151
5.1: Factors that may facilitate Johnny’s pursuit of employment	170
5.2: A Case Study of a ‘Positive’ Trajectory (Bev)	176 – 177
5.3: A Case Study of a ‘Fluctuating’ Trajectory (James)	181 – 182
5.4: A Case Study of a ‘Static’ Trajectory (Arnie)	186 – 187
5.5: Joseph’s Living Room (Positive Trajectory)	192
5.6: Jimmy’s Living Room (Static Trajectory)	192
5.7: Carl’s Living Room (Fluctuating Trajectory)	193
5.8: Arnie’s Living Room (Static Trajectory)	193
5.9: Participants’ Converted SWEMWBS scores	199
5.10: Participants’ ‘Social Trust’ Scores across each wave	203
6.1: Temporal Mapping of Needs and Capabilities in the Life Histories: ‘Middle Aged Desisters’	225 – 226
6.2: A Case Study of Johnny	230
6.3: Temporal Mapping of Needs and Capabilities in the Life Histories: ‘Young & Excluded’	231 – 232
6.4: A Case Study of Linda	236
6.5: Temporal Mapping of Needs and Capabilities in the Life Histories: ‘Ageing Drinkers’	237 – 238
6.6: A Case Study of Jimmy	243
6.7: Temporal Mapping of Needs and Capabilities in the Life Histories: ‘Severely Disadvantaged’	244 – 246
6.8: A Case Study of Lyla	251

7.1: Liam's crutches and the stairs up to his flat	284
---	-----

Tables

2.1: Desired outcome areas outlined in the Newcastle Multiple Exclusion Service Contract	59
2.2: A comparison of key Housing First principles and principles outlined in the Newcastle Service Contract	60
4.1: Outcome domains and Sub Domains measured in this Study	114 - 115
4.2: Psychometric measures used in this study and domains to which they contribute	116
4.3: Basic Demographic Information for all Study Participants	129
4.4: Number of Interviews by Wave and Type	130
5.1: Participants' personal outcome priorities for the duration of the study (16 months)	163
5.2: Participants' personal outcome priorities, sequenced, and ordered according to how often each was stated	165
5.3: How Participants' Priority Outcomes fit with Service Outcomes	167
5.4: Trajectories of participants towards outcome domains over 16 months	174
5.5: Housing Retention Rates for Study Participants	190
6.1: The Extent of Needs in the Life Histories of Participants	223
6.2: The Extent of Capabilities in the Life Histories of Participants	224
6.3: Participants' Life History 'Types' plotted against Outcome Trajectories	252

Abbreviations

ACT	Assertive Community Treatment
DWP	Department for Work & Pensions
ESA	Employment Support Allowance
HF	Housing First
ICM	Intensive Case Management
JSA	Jobseekers' Allowance
LHA	Local Housing Allowance
MEH	Multiply Excluded Homeless
PRS	Private Rented Sector
SAT	Situational Action Theory
SMD	Severe and Multiple Disadvantage
SWEMWBS	Short Warwick Edinburgh Mental Wellbeing Scale
UK	United Kingdom

1: Introduction

The most basic premise of the 'Housing First' (HF) model is that homeless individuals should be offered independent accommodation as quickly as possible. To the general public, this may not seem a particularly radical idea. However, for those who have worked in, or studied, homelessness provision in North America and Europe, HF is widely understood as a radical departure from traditional models of service provision (Pleace, 2012). These traditional models are based on the idea that before being offered independent housing, homeless individuals must be 'treated' to overcome their barriers to 'housing readiness'.

In the late 20th century, critical voices began to argue that this 'treatment first' philosophy acts to exclude certain groups of homeless individuals, specifically those with 'multiple and complex' needs (Ridgway & Zippel, 1990). The term 'multiple and complex' refers to overlapping experiences of substance misuse, mental health issues, offending, and 'street culture' activities. These needs often originate before experiences of homelessness, borne out of long periods of social and economic disadvantage and exclusion (Fitzpatrick & Bramley, 2015; Fitzpatrick, Bramley, & Johnsen, 2012). However, these individuals also experience longer periods of homelessness, which compound their needs further. Consequently, in the UK, these individuals have been termed 'multiply excluded homeless' (MEH) adults (Fitzpatrick, Johnsen & White, 2011).

The HF model emerged from these critical perspectives, and offers immediate, independent housing to homeless adults with complex needs. Since then, implementations of HF have repeatedly demonstrated high rates of housing retention, challenging the assumption that this group cannot maintain independent accommodation (Woodhall-Melnik & Dunn, 2015). There is also a strong movement surrounding the model, which promotes it as a more humane approach to supporting homeless individuals (Padgett, Gulcur, & Tsemberis, 2006). In order to encourage a move away from congregate accommodation projects informed by a 'treatment first' ideology, many

accounts of HF focus overwhelmingly on positive housing related outcomes, rather than the significant challenges faced by MEH adults after entering independent housing. As a result, some academics have argued for further consideration of what 'success' refers to in HF (McNaughton Nicholls & Atherton, 2011).

Although important for the model's proliferation, a focus on housing related outcomes does risk overlooking what comes after. In HF, housing is supposed to be the start of the journey, not the end. After housing, clients face multiple journeys of recovery and desistance, each of which are made more challenging by their intersection with each other. As outlined in section 2.5, HF was designed as an augmentation to Assertive Community Treatment (ACT) that primarily focuses on supporting processes of recovery. HF was not simply designed to show that with support, MEH adults can maintain independent housing. Housing was supposed to be the foundation for support and treatment that enabled meaningful, positive change in clients' lives. This study is primarily concerned with this more ambitious aim.

It is important to note that this study does not seek to challenge or critique the humanitarian focus of the model, nor its uniformly encouraging evidence base around housing retention and client satisfaction. However, it does seek to ask if 'housing comes first, what comes after?' What are the lived realities of HF for MEH adults in particular social, political and economic contexts? In doing so, this thesis aims to first highlight, then interrogate the specific mechanisms by which HF aims to enable MEH adults to achieve desirable outcomes. In HF, these mechanisms are inherent within the model's principles, which emphasise the importance of giving 'choice and control' to the client.

The widespread proliferation of the HF model has led to important questions about how HF is delivered (Pleace, 2011). Particularly, the extent to which new implementations balance fidelity to the original, and tailoring the model to their specific context of service delivery (see section 2.6). By focusing on the experiences of one particular implementation in Newcastle, it is hoped that more can be learned about what it means to

deliver HF. Particularly in a UK context where there is a paucity of research on the model. The findings presented are, to a large extent, specific to the study context, although some shared experiences are expected across all implementations of HF. In turn, many of the findings presented in this thesis are representative of those in larger evaluations.

The model's proliferation has necessarily relied on larger scale, quantitatively orientated trials favoured by policy makers. However, exploring highly individualised processes of recovery and desistance necessitates in depth analysis, inherent in 'small n', qualitatively orientated research designs (Maruna, 2015). The strength of this research lies in its analytical focus, presenting the lived experiences of one cohort of MEH adults in HF. In doing so, this study interrogates the principles and mechanisms of HF as they manifest in a specific context. Large scale, randomised control trials are an essential foundation, establishing *if* HF enables outcomes, and *which* outcomes it enables. However, rich and detailed qualitative enquiry is just as essential in explaining *how* HF produces outcomes, and *for who*.

1.1: Research Objectives

This thesis aims to highlight and interrogate the mechanisms used in HF to enable clients to achieve a subjectively positive and meaningful life. Particularly, how these mechanisms manifest in the social, political, and economic context of a single implementation. More specifically, this thesis explores notions of choice and control in a HF model and how these contribute to the achievement of successful outcomes for MEH adults.

Three primary research objectives were identified to aid exploration of these aims:

- To establish the desired outcomes of Housing First for clients, and how these fit with wider definitions of 'success' for 'Multiply Excluded Homeless' adults.
- To explore the extent to which 'choice and control' was available to clients
- To explore which environmental and biographical factors affect clients' ability to utilise 'choice and control' to achieve outcomes.

Therefore, this study focused on three key concepts: 'success', 'choice', and 'control'. 'Success' in HF is interrogated in terms of what comes after being housed. The question of what constitutes 'success' is explored throughout Chapters 2 and 3, before being summarised in early sections of Chapter 4. Ultimately, it becomes clear that 'success' beyond housing is a highly subjective concept, albeit one which is also determined by wider social norms and structures. Recovery and desistance are inherently personal pursuits of moving away from subjectively harmful behaviours and towards subjectively positive and meaningful lives. To support these pursuits, HF aims to enable 'choice and control' for clients.

The principles of HF give clients greater control than they receive in provision guided by a 'treatment first' philosophy. HF gives clients control over material resources (independent accommodation), and relative autonomy over behaviour and support. HF also aims to shift the social norms that surround clients through independent housing, and community based support, away from the negative influence of congregate housing situations, which contain high numbers of individuals with similar needs and behavioural preferences.

Choice is the mechanism by which clients are able to pursue recovery-orientated outcomes. By removing the conditions placed on clients in 'treatment first' models, it is hoped that they will be free to make choices which aid the pursuit of a positive and meaningful life. However, this mechanism has faced stringent criticism both in HF and in social policy literature more broadly (see Chapter 2). These critiques have highlighted that individuals have variable capacities to make choices with positive outcomes, due to a complex range of factors in their personal histories and environments (Greve, 2011; Rose & Miller, 2008).

Positive accounts of choice in HF demonstrate the relationship between choice and greater satisfaction, but this does not necessarily mean a better life for participants in which they achieve greater social and economic inclusion. This study aims to interrogate

the mechanism of choice as a means of pursuing 'success'. Employing a situational approach, the study highlights the key personal and environmental factors that both improve and restrict participants' capacity to utilise the mechanism of choice in order to achieve desirable, recovery-orientated outcomes. By doing so, it is hoped that much can be learned about how the model can continue to develop and improve. More specifically, important questions are asked about how the mechanism of choice and HF more broadly, operates in a UK context from which many critiques of 'choice' emerged. This study centres on a firm belief that through more critical, detailed enquiry into the experiences of particular clients, HF can enable better outcomes for clients.

Although, the key objectives and arguments of the thesis are summarised at the beginning of this section. It is worth highlighting the key points of each chapter individually to aid clarity when reading the rest of the thesis.

The main body of the thesis begins with a thorough review of the HF model in Chapter 2, offering a contextual grounding for the remainder of the study. The chapter begins by explaining 'linear residential' models of homelessness provision, broadly informed by a 'treatment first' philosophy. HF emerged in response to critiques of this model and philosophy. However, HF also followed broader trends in service provision in mental health and substance misuse. After outlining the design and evidence base associated to the original 'Pathways' implementation, the chapter then turns to the proliferation of HF across North America and Europe. In each new area, similar outcomes around housing retention, and service satisfaction are emphasised. In turn, 'success' in HF risks becoming narrowly defined by housing, rather than overcoming needs and achieving greater social and economic inclusion. After reviewing the model's evidence base, section 2.7 reviews each of the principles that underpin HF. Doing so emphasises that housing related outcomes, though desirable, are just the beginning. Each principle is itself 'recovery orientated', rooted in key trends and practices in mental health and substance misuse recovery, as well offending desistance. The chapter concludes by

detailing the context in which this study takes place. These sections explore the national (section 2.8.1) and local (2.8.2) service delivery and policy context in which the HF service operates, clients' choices are made, and participants' recovery and desistance processes take place.

Chapter 3 picks up questions posed in Chapter 2 by exploring theoretical approaches to defining and measuring 'success' and 'choice'. More specifically, this chapter is concerned with MEH adult's ability to pursue recovery-orientated outcomes. As such, the factors related to their personal biography or environment, which may affect this pursuit, are of primary concern. After exploring the type of choices clients make in section 3.2, and reviewing broad literature on rationality and decision making in sections 3.3 – 3.4, a situational approach is selected as the broad analytical framework for this study.

A situational approach and the analytical realist perspective from which it originates place the individual at the centre of analysis, believing this to be as the best way to understand their choices, as well as the resulting actions. Later sections are structured by the three overarching components of a situational approach; person, setting, and time. Each component provides a base from which to explore the factors that may facilitate or hinder participants' capacity to utilise the mechanism of choice effectively. The personal factors which affect participants' capacity for choice are drawn into three interrelated categories; 'preferences', 'needs', and 'capabilities'. Literature outlined in Chapter 2 supported the definition of what constitutes 'success' beyond housing in HF. In Chapter 3, Sen's (1993) capabilities approach is employed within a situational framework as a theoretical guide for personalising the measurement of success to each participant (see section 3.5.2). Relevant environmental factors are categorised according to 'norms', 'opportunities', and 'resources'. Particular attention is paid to participants' 'local social networks' which have a particularly prominent role in influencing individual action.

Chapter 4 moves from the explanation of theory, to its application by outlining the methodological approach used in this study. The early sections of Chapter 4 offer a

summary of the key points of Chapter 2 and 3, before discussing the broad ontological and epistemological approaches that inform the research design. The remainder of the chapter is structured according to the chronology of the study. Sections 4.1.4 – 4.3.2 describe the initial stages of the study with reference to the predominately-qualitative longitudinal design, approach to outcome measurement, and sampling and recruitment methods respectively. Section 4.4 covers each consecutive wave of the study, explaining the methods, formative analysis, and resulting innovations and developments at each wave of data collection. Chapter 4 concludes by explaining the final summative analysis undertaken after all data collection had been concluded. This study seeks to explore notions of choice, control and success through detailed, analytical enquiry into each participants' experiences. As a result, analysis first took place on a case-by-case basis. Cross-case analysis then revealed key similarities and differences in participants' experiences.

The remaining three chapters outline the study's findings. Chapter 5 utilises the theoretical and methodological approaches outlined in earlier chapters to define and measure 'success' for participants in this study. As such, this chapter was concerned with contributing to the first research objective; *establishing the desired outcomes of Housing First for clients, and how these fit with wider definitions of 'success' for 'Multiply Excluded Homeless' adults*. Chapter 5 began by outlining the nature of participants' priority outcomes for the duration of the study. Later sections situate these priorities within a broader range of relevant outcomes, highlighted with reference to individual domains. Sections 5.4.1 to 5.4.8 comment on participants' achievement of outcomes in each of these domains.

In section 5.3, participants are organised into one of three trajectories, indicative of the extent to which they have achieved, and moved towards recovery orientated outcomes more broadly. It becomes clear that participants trajectories differ considerably, indicating inequitable capacity to utilise the 'choice and control' offered in HF to achieve

desirable outcomes. The remaining chapters are concerned with explaining these inequities.

Chapters 6 and 7 examine participants 'situational capacity' to achieve these outcomes within a HF service. Therefore, Chapters 6 and 7 are concerned with *exploring which environmental and biographical factors affect clients' ability to utilise 'choice and control' to achieve outcomes* and ultimately *examining the role of choice and control in the achievement of 'successful' outcomes*.

In line with a situational approach, Chapter 6 is concerned with those factors related to participants' personal histories. Before exploring these 'personal' factors, the chapter begins by outlining participants' perceived choice over housing, support, and behaviour in HF. In doing so, this section begins to *explore to extent to which 'choice and control' was available to clients*. Comparisons are made to HF literature on choice, which primarily relies on these more abstract notions of choice. Informed by the theory outlined in Chapter 3, section 6.3 explores participants' personal capacity for recovery and desistance orientated choices essential in achieving outcomes defined in Chapter 5. The incidence of relevant 'needs' and 'capabilities' in participants' personal histories are outlined. In doing so, key similarities and differences amongst participants life histories allow a 'typology' to be developed. Each 'type' present different needs and capabilities for utilising choice to achieve desirable outcomes.

Chapter 7 is concerned with the environmental factors that influenced participants' capacity to utilise choice to achieve recovery-orientated outcomes. The typology outlined at the end of Chapter 6 is predictive of the nature of environmental factors that either hinder or facilitate positive outcome trajectories. Therefore, much of Chapter 7 is structured by this typology. Sections 7.3.1 to 7.3.4 highlight the differential nature of factors that affected each participants' capacity to utilise choice and reach desirable outcomes, according to their 'type'. These environmental factors are structured according to the four key areas that emerged during analysis: housing, local social networks,

service, and wider service stakeholders. Each of these areas have wider implications for the opportunities and resources available to participants as they seek to overcome needs, and pursue a positive and meaningful life. These areas also imply the social and moral norms that surround participants during their time in HF, influencing their choices and offering competing definitions of 'success'. Therefore, discussion of each of these concepts is implicit throughout the presentation and discussion of findings.

This chapter has introduced the purpose and structure of this thesis. Chapter 2 now begins the main body of the thesis by introducing the origins, philosophy, proliferation, and evidence base of the HF model.

2: Housing First: Origins, Philosophy, Proliferation, and Outcomes

2.1: Introduction

The Housing First (HF) model is widely understood as a radical departure from traditional models of support for homeless people facing ‘multiple and complex’ needs due to its focus on community based treatment and respect for client choice and control. The model’s evidence base has demonstrated very positive short to medium term outcomes, in particular around housing retention (Waegemakers Schiff & Rook, 2012; Woodhall-Melnik & Dunn, 2015). This has led to rapid and widespread adoption of the model across North America and Europe.

This chapter interrogates just how radical and effective HF is by exploring the contextual and historical origins of the model, as well as its proliferation. The chapter begins by briefly outlining the historical origins of the ‘treatment first’ ideology and linear residential treatment models which preceded HF, and still dominate homeless provision in many countries (Johnsen & Teixeira, 2010). A ‘treatment first’ philosophy has been faced with a chorus of critical voices, many of which have focused on a subset of the homeless population who are commonly categorised as ‘multiply excluded homeless’ (MEH). Across western developed countries this subset seem to fair worst amidst the more paternalistic ‘treatment first’ philosophy. In turn, this group share common experiences of multiple needs such as mental health, substance misuse and offending.

The following section (2.6) interrogates the wider adoption and effectiveness of HF in tackling homelessness, intersected with ‘multiple and complex’ needs. The section is structured around the major areas in which the model has been adopted, namely the US, Canada, and Europe, with two key points emerging. Firstly, that during the process of proliferation HF has become more broadly and loosely defined, placing greater emphasis

on the importance of fidelity to the model's principles. Secondly, it is demonstrated that although outcomes associated to service satisfaction and housing retention are clear, longer term outcomes related to substance misuse recovery, offending desistance and engagement in 'meaningful activities', such as employment are less forthcoming.

In section 2.7, attention turns to the principles retained throughout implementations of HF. In doing so, it becomes apparent that many of these principles are largely representative of trends in mental health, addiction, and offending, with each emphasising 'recovery orientated' approaches. Particular attention is paid to the principle of client 'choice and control'. This principle promotes the use of consumer type choices for clients as a mechanism for pursuing longer-term outcomes. This principle underpins all others in the model. It is also attributed outcomes with relatively little supporting evidence. In addition, the principle is utilised without taking account of the complex decision making process involved in making choices, an issue picked up in Chapter 3. Finally, section 2.8 explores the context in which the Newcastle implementation of HF operates. There is a paucity of evidence for the model's effectiveness in the UK, perhaps due to the model's relatively late adoption. With reference to the principle of 'choice and control', a wealth of UK social policy literature is highlighted that suggests that the mechanism of consumer type choice produces inequitable outcomes for marginalised groups. As a result, further examination into the relationship between the principle of client 'choice and control' and 'successful' outcomes in the UK is required.

2.2: Treatment First Ideology

To understand HF as a service model and treatment philosophy it is necessary to detail the particular policy context in which it arose. This requires a brief departure to the 1950s where in the US as well as in many European countries, a process of deinstitutionalisation began with widespread closure of psychiatric hospitals (Accordino, Porter, & Morse, 2001; Lamb, 1993; Turner, 2004). Deteriorating conditions in psychiatric

hospitals combined with troops returning from the Second World War with mental health issues, supported a shift to more community based, vocational treatment for severe mental illness (Accordino et al., 2001). A similar trend also emerged in the UK, more broadly attributed to a shift in social philosophy (Turner, 2004). In the following two decades a range of different service options were developed, including outpatient services and partial hospitalisation. These services were set within various linear residential treatment (LRT) programmes that aimed to enable recovery by progressing through various services with greater levels of independence enabled at each.

In the US in the 1980's greater numbers and wider demographics were becoming homeless, including individuals with persistent mental health and substance misuse issues. Initially emergency shelters were set up but after the recession subsided, it became increasingly clear that service provision was not meeting the needs of the heterogeneous group of homeless people, particularly those with needs that are more complex (Wong, Park, & Nemon, 2006). The 'continuum of care' model emerged as the favoured means of organising support, closely replicating LRT models in mental health provision. The emergency shelters set up during the recession were retained as the 'bottom step', with transitional housing and permanent supportive housing developed for individuals to progress into (Ridgway & Zippel, 1990). To progress through 'steps' clients were required to adhere to a range of conditions related to 'housing readiness'.

Due to its tiered nature, the 'continuum of care' model has also been conceptualised as the 'staircase approach' (Sahlin, 2005). However, in the UK the model has been likened more to an 'elevator', with individuals sometimes skipping stages of progression and commonly moving 'up and down' through levels of independence according to behaviour (Johnsen & Teixeira, 2010). Although there are some variations in these models, they basically tie housing to services as individuals graduate to more independent forms of housing as they prove service engagement, sobriety and certain standards of behaviour. As such, these models can be understood as guided by a

'treatment first' philosophy, predicated on assumptions of the need for structure and control. In exchange for accommodation and as a necessary precursor for behavioural change clients submit to conditions which commonly included treatment compliance, abstinence, curfews, communal living, and limits on the number of visitors (Padgett et al., 2006). Such conditions are synonymous with a 'minimalist' explanation of what causes homelessness (Takahashi, 1996). Focusing on 'treating' homeless individuals conceptualises them as either *deviant*; becoming homeless due to their own immoral choices, or *incapable*; lacking the capacity to live independently (Parsell & Parsell, 2012). Culhane and Merteaux (2008) have argued that such models are not cost efficient, are ineffective at achieving outcomes, and do not address the causes of homelessness. Further, they expose residents to victimisation and trauma. Busch-Geertsema (2013: 16) provides a useful summary of the critiques associated to 'continuum of care' models:

- Stress and dislocation caused by the need to move between different accommodation-based projects,
- A lack of service user choice and freedom combined with standardized levels of support in the different stages of residential services,
- Decisions about when and where clients are placed are made by service staff and clients are afforded little privacy and control (at least in the "lower" stages),
- Skills learned for successful functioning in a structured congregate setting are not necessarily transferable to an independent living situation,
- The final move into independent housing may take years, and between the different stages many clients get "lost",
- Revolving door effects and an entrenched group of "frequent flyers" stuck within the system (i.e. MEH adults)

These problems were set within wider academic criticisms, which continued through the 1990's and early 2000's in a North American context (Davis, 1990; Mitchell, 1997; Mitchell, 1998a, 1998b; Smith, 1992, 1996; Sorkin, 1992). These critical narratives

emphasised neoliberal politics and geographies of social control concentrated on moving homeless people out of prime spaces (Cloke, May, & Johnsen, 2010). Other studies concentrated upon the marginalised spaces such as 'skid row' that these excluded individuals moved to and congregated, often because they were unable to 'progress' to the next tier of housing (Dear & Wolch, 1987; Herring, 2014; Wolch, Dear, & Akita, 1988).

2.3: The Complex and the Excluded

Amongst others, Kuhn and Culhane (1998) highlighted that individuals with multiple needs were using emergency shelters more frequently, and over longer periods. Kuhn and Culhane's (1998) seminal analysis demonstrated that these chronic shelter users (as opposed to episodic or transitional users) while only representing 11% of shelter users, accounted for 50% of the total shelter use. Multiple needs and the anti-social manifestations of these needs also pushed up the costs associated to this group by increasing contact with statutory health, social care and criminal justice.

Individuals with similar issues and experiences of homelessness are apparent across the western world (Toro, 2007). In each of these contexts their behaviour and needs conflict with traditional models of response, which emphasise compliance to structured treatment before housing. Those individuals who most commonly break the norms set out by service providers and police face exclusionary consequences more frequently, acting to compound their already precarious situation. Although these consequences are partially designed to encourage individuals to change their behaviours, a 'hardcore' remain.

In the UK, a similar subset have been referred to as 'multiply excluded homeless' (MEH) (Cornes, Joly, Manthorpe, O'Halloran, & Smyth, 2011; Fitzpatrick et al., 2011). The term references the repeated exclusion of individuals from homeless accommodation and services, as well as their broader experience of other forms of deep social exclusion; such as substance misuse, histories of institutional care, mental health issues, and 'street

culture' activities (Harding, Irving, & Whowell, 2011; Harding, Irving, Fitzpatrick, & Pawson, 2013).

Minimalist accounts emphasising deviant behaviour and personal choice as the root cause of homelessness have been replaced by a 'new orthodoxy' in homelessness research, highlighting a combination of structural, institutional and personal factors (Neale, 1997; Fitzpatrick, 2005). In particular, research has demonstrated the close link between experiences of poverty and the likelihood of becoming homeless (Johnsen & Watts, 2014; Shinn & Gillespie, 1994).

Nevertheless, it is still possible to see how certain homeless 'identities' (McCarthy, 2013) continue to be framed as being irresponsible, lacking control and not being able to exercise rational choices to take control of their own lives (Fitzpatrick & Stephens, 2014). In these cases, the responsibility for maintaining homelessness remains with many single, homeless individuals, particularly those who experience rough sleeping over the longest periods of time; the 'multiply excluded' homeless. As a result, these individuals are commonly characterised as 'chaotic', presenting an image of their behaviour as unhinged and irrational, or as helpless and unable to control themselves (Parsell & Parsell, 2012).

2.4: Supportive Housing

Parallel to a critical academic narrative, the supportive housing model emerged in the early 1990's in the US. This model promoted community integration and scattered site housing instead of congregate housing, and 'client choice' instead of paternalistic conditions (Carling, 1995). 'Floating' support services tailored the support required to the individual at any given time. Cloke et al. (2010) highlight that since the 1980's neoliberal governments have placed an emphasis on supply side innovation, competitiveness, privatization and deregulation to manage the economy as well as public services. Supportive housing fitted well with this model as it did not require any fixed site infrastructure, meaning service costs were cheaper than those in services guided by a treatment first philosophy (Tabol, Drebing, & Rosenheck, 2010; Tsemberis & Eisenberg,

2001). A number of studies also suggested more positive outcomes for service users. In particular, rates of housing sustainment were higher in floating support services than those in fixed site, 'continuum of care' services (Pleace & Wallace, 2011; Ridgway & Zippel, 1990).

2.5: Pathways Housing First

Waegemakers Schiff and Rook (2012) identified three 'founding' supportive housing programmes, one of which was Pathways to Housing. Pathways was founded in New York in 1992 with the aim of providing permanent housing and treatment for chronically homeless and mentally ill people in New York City (McNaughton Nicholls & Atherton, 2011). The model centres on the belief that stable housing is essential for providing life-changing services (Knutagård & Kristiansen, 2013; Tsemberis & Eisenberg, 2001; Tsemberis, Gulcur, & Nakae, 2004).

Pathways provided accommodation to augment an Assertive Community Treatment (ACT) model of support, discussed later in this section. In turn, some have postulated that the model of treatment and support was the philosophical foundation upon which the model was developed (Woodhall-Melnik & Dunn, 2015). The actual term 'Housing First' was later coined by the National Alliance to End Homelessness in 1999 (Atherton & McNaughton Nicholls, 2008). The principles of Pathways Housing First (PHF) are as follows:

- Housing is a human right and is central to supporting individuals out of homelessness. Therefore, housing is offered immediately.
- Housing should be independent and scattered within the community to allow individuals to live indistinguishable from other residents as this is a fundamental aspect of recovery.
- Consumers have choice over their services.

- A harm reduction approach is taken to alcohol and drug addiction with no requirement of abstinence or engagement in recovery programs as a requirement of maintaining housing.
- Consumers have access to a wide range of support offered through a multi-disciplinary team on call 24/7 to support with issues including housing, health care, medication, employment, family relations, and recreational opportunities. This is offered separate to housing and does not influence it.
- Respect, warmth and compassion for all consumers.
- A commitment to working with consumers for as long as they need.

(Pleace, 2012; Stefancic & Tsemberis, 2007)

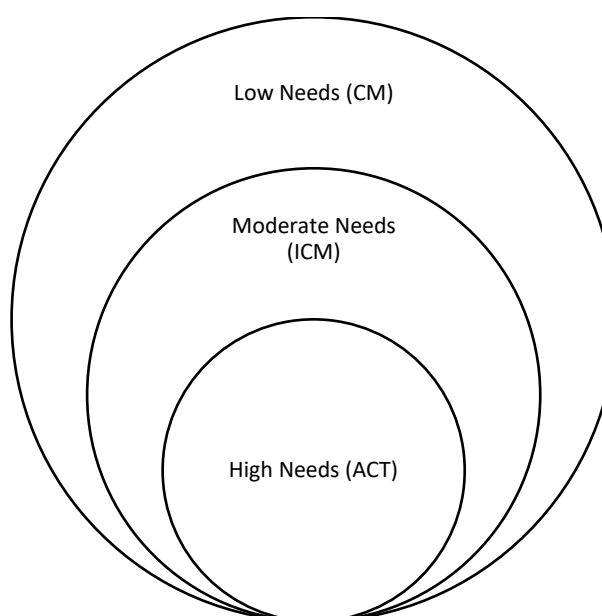
Pathways make no prior assessment of an individual's ability to maintain a tenancy, differentiating the model from 'treatment first' or 'linear' approaches to which the model is largely a response (McNaughton Nicholls & Atherton, 2011). Tsemberis (2010) reports a housing retention rate of 85%, challenging the belief that this client group are unable to maintain independent accommodation (Pleace, 2012).

Because the ability to change property is necessary for adherence to client choice over housing, Pathways held leases for nearly 600 privately rented properties in New York. This approach limits any concerns about letting to homeless people with mental health issues, as the tenancy agreement is between Pathways and the landlord. However, a sub-letting agreement does arguably differentiate consumers from other private tenants and limit their rights as consumers.

Housing is provided immediately (or as quickly as possible) and on an open-ended basis. There is no requirement for compliance with psychiatric treatment or for abstinence from drugs or alcohol. The only explicit conditions of PHF are that service users must agree to a weekly visit from Pathways support workers and pay 30% of their monthly income towards rent (Tsemberis, 2010).

In order to receive support from 'Pathways to Housing', an individual is required to have a diagnosed clinical disorder and be chronically homeless (either two years in a hostel or three months rough sleeping, as well as being eligible for public assistance funds) (Tsemberis, 2010). A team of tenancy support workers supported consumers to maintain accommodation; wider support is allocated based on an assessment of need. A multi-disciplinary Assertive Community Treatment (ACT) service concentrates on people with the severest forms of mental illness and Intensive Case Management (ICM) is available for those with less severe diagnoses (Pleace, 2011). ICM consists of a single case manager to work with clients and supports access to other more specialist services. In contrast, an ACT team consists of psychiatric nurses, employment support workers, substance use support workers, peer workers, family specialists and so on (Bond, Drake, Mueser, & Latimer, 2001). Later, Tsemberis promoted the allocation of support according to a more general assessment of need, as displayed in figure 2.1.

Figure 2.1: Allocation of Support According to Need in Housing First¹



As HF has spread to different policy, housing and service delivery contexts, ICM has become the most common model of support. This is perhaps surprising since HF

¹ Adapted from Tsemberis (2013) presentation to the International Housing First Conference. Available at: <http://hf.aeips.pt/wp-content/uploads/2013/10/Tsemberis.pdf>

emerged as an augmentation to ACT. The most likely reason is the reduced cost of ICM as opposed to ACT as well as the difficulty of providing joined up services from a range of different sectors (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009). In addition, an ACT approach requires exemplary interdisciplinary communication and working around specific individuals. In the large-scale Canadian demonstration project 'Chez Soi/ At Home', ACT was offered to higher needs participants at a cost of C\$22,257 per person per year. ICM was offered to moderate needs participants at a cost of C\$14,177 per person per year. Although, more expensive, ACT generated greater average savings for higher need participants than ICM for those with moderate needs. (Aubry, Nelson, & Tsemberis, 2015).

In their literature review of ICM and ACT interventions Nelson, Aubry, and Lafrance (2007) found that each brought better outcomes than controls in similar areas. ACT was more prolific in enabling outcomes but the difference was not significant. Outcomes that improved included engaging clients in treatment, reducing psychiatric hospital use and increasing housing stability, and to a lesser extent the improvement of psychiatric symptoms and subjective quality of life.

One important consideration noted by Nelson et al. (2007) is that ACT and ICM focus on initial, basic needs for housing and support. These needs are important but must be followed by support to meet longer-term outcomes and to develop empowerment. There is little evidence to suggest which model enables better life choices but there is an acceptance that ACT is a more appropriate intervention for those with higher needs.

ACT has been critiqued for restricting choice by providing support that is too intensive and 'assertive'. However, Bond et al. (2001) argue that ACT may actually improve the level and range of information available to clients given the specialist knowledge of each professional. In turn, assertive and holistic support have been noted as important factors in the success of HF implementations, particularly when delivered alongside housing, by a single organisation (McNaughton Nicholls & Atherton, 2011).

What seems to be essential is to offer support assertively, while still adhering to a philosophy of client choice and control, with the role of support being to inform these choices with the most appropriate information. In an ICM model, the ability to inform choices will rely on gaining access to other specialist services.

This section has focused primarily on the origins of HF as part of the supportive housing movement and in response to the issues with a 'treatment first' philosophy. 'Pathways to Housing' defined HF as we know it today, highlighting the importance of housing rights, community based support, and a respect for client 'choice and control'. The next section examines the proliferation of the HF model, focusing on the two global regions in which there have concerted efforts to implement a HF approach, North America and Europe. Two key themes run through this section. Firstly, the extent to which the fidelity to the original model and principles can be retained in other service delivery contexts. Secondly, the extent to which a HF achieves favourable outcomes for adults facing homelessness and multiple needs.

2.6: Proliferation of the model

2.6.1: US Proliferation and Policy Context

The consensus among those researching HF is that the rapid expansion of the model centres on the rigorous evaluative framework its founders applied (Pleace, 2012; Tsemberis & Eisenberg, 2001; Tsemberis et al., 2004). Specifically comparing HF with traditional 'continuum of care' services that still dominate in most western countries. However, the process of proliferation depended on more than Pathways ability to demonstrate comparatively better outcomes. Baker and Evans (2016) note that the congruence between HF and wider projects of welfare retrenchment and fiscal austerity were also important. More specifically, a policy context that gave preference to 'evidence based policy' and cost effectiveness was a necessary foundation for proliferation of HF (Stanhope & Dunn, 2011). Evidence based policy rose to prominence under the Bush

administration after being articulated and practiced by the New Labour government in the UK, amongst a proposed shift away from ideological influences on policy-making and a wider tendency towards neoliberalism in Europe and the US (Stanhope & Dunn, 2011). There is no agreed definition but the expectation is that policies are introduced based on research evidence and that policies are trialled and rigorously evaluated. (Plewis, 2000 c. Stanhope & Dunn, 2011). The relationship between policy and research has in fact been more tenuous in the US. Culhane (2008) notes that research projects have been often been small scale, focused on specific, short-term programs.

Within this context, the large randomised control trials undertaken by Pathways were able to demonstrate more positive short to medium term outcomes than treatment as usual. Favourable housing retention rates were particularly promising for a group often perceived as unable to maintain accommodation (Salyers & Tsemberis, 2007; Stefancic & Tsemberis, 2007; Tsemberis, 2014). However, there is some evidence that the people with severe mental illness PHF was working with were *less likely* to present with severe substance use issues, than those in the 'treatment as usual' cohort (Kertesz et al., 2009).

Nevertheless, subsequent evaluations have demonstrated similar outcomes across a range of different countries and contexts (Busch-Geertsema, 2013; Goering et al. 2011; Knutagård & Kristiansen, 2013; Tainio & Fredriksson, 2009). The extent to which HF is effective in achieving longer-term outcomes is less clear.

As well as positive short to medium term outcomes, cost savings were also an important factor in HF's proliferation. The high costs associated chronic homelessness were a key catalyst for President Bush to make ending chronic homelessness a top priority in his budget in 2003, increasing funding by 35% (Caton, Wilkins, & Anderson, 2007). As outlined in section 2.4, supportive housing does not require fixed site infrastructure, making it a cheaper alternative. More recently, a review by Ly and Latimer (2015) highlight that significant evidence exists to suggest that shelter and emergency department costs do decrease with HF.

The establishment of city and state '10 year plans to End Homelessness' followed and the promise of improved outcomes at lower costs led to HF models becoming government sanctioned best practice (Willse, 2010). What resulted was a rapid proliferation of HF approaches that had little fidelity to the Pathways model from which evidence emanated (Kresky-Wolff, Larson, O'Brien, & McGraw, 2010). The model provided an enticing political solution to reducing levels of homelessness. By offering immediate housing, 'homelessness' is solved in the first instance by HF. However, understanding and funding HF through the policy lens of homelessness may limit the recovery prospects of HF clients. The original purpose of HF was to utilise independent housing as the most appropriate setting for treatment and recovery from mental health and substance use needs. For this reason, many of the model's principles are representative of wider trends in mental health and addiction recovery agendas, as demonstrated in section 2.7. By focusing on shorter-term outcomes related to housing retention, HF risks becoming a cheap solution to reducing homelessness figures.

2.6.2: International Proliferation and Variation

Context and Fidelity

Johnson et al. (2012) echo Kresky-Wolff et al.'s (2010) US findings by observing that while many implementations espouse a commitment to the model, few deliver in the same way as Pathways. Baker and Evans (2016) attribute this lack of fidelity to differences in political ideology, welfare systems, and practitioner cultures. In turn, Atherton and McNaughton Nicholls (2008) argue for research in local contexts to highlight obstacles to implementation. Pleace (2011) shared similar concerns in his analysis of ambiguities and risks of adopting HF from a European perspective, noting a lack of clarity about what 'HF' services are delivering.

The original proponents of HF have since created a fidelity criteria and scale for new 'HF' projects to be analysed against (Gilmer, Stefancic, Sklar, & Tsemberis, 2013).

Although there may be divergence amongst HF projects, most implementations share the assumption that chronically homeless people do not have to be sober and compliant with psychiatric treatment before they can be successfully re-housed, and that giving choice and control to service users will provide more sustainable exits from homelessness (Kertesz & Weiner, 2009).

Defining 'Success' in Housing First

In their systematic review of HF outcomes, Woodhall-Melnik and Dunn (2015) identify that generally speaking, HF evaluations have been methodologically rigorous. They specifically note that there is strong, consistent evidence that HF enables improved housing retention. The authors do concede that the majority of studies have emerged from a North American context. However, evidence in a European context is also growing. Randomised control trials (Tinland et al., 2013) and single site evaluation studies (Bernad, Yuncal, & Panadero, 2016, Johnsen, 2014) have demonstrated similarly positive short term, housing related outcomes.

However, McNaughton Nicholls and Atherton (2011) argue that in order to robustly assess the effectiveness of HF, there is a need to consider what 'success' actually refers to in the resettlement of formerly homeless people. In two separate papers, Kertesz recognised the importance of not seeing HF as an immediate panacea to the issue of homelessness (Kertesz et al., 2009; Kertesz & Weiner, 2009). This is particularly true when we consider that the wider goal of the model is not simply to offer a political solution to ending homelessness, but to enable a positive life for those the service targets. The limited outcomes around substance misuse and meaningful activities point towards less convincing outcomes in the longer term (Busch-Geertsema, 2013; Kertesz et al., 2009; Woodhall-Melnik & Dunn, 2015). Pleafce supports Kertesz, stating that questions remain about whether HF services can address the wider needs of 'chronically homeless' people. In turn, he raises concerns that the policy and research focus on HF is overemphasising one aspect of the wider social problem of homelessness.

As a result, Caton et al. (2007) argue that there is a need to understand various HF services in order to assess which variants work well and which may work less well. Covering all implementations that identify as 'Housing First' would not be viable or favourable. Instead, the following section focuses on key implementations in particular countries or continents, each of which raise particularly important issues for this study.

Canada

The Canadian Government allocated \$110 million to the Mental Health Commission of Canada (MHCC) to undertake a research demonstration project on homelessness and mental health. Launched in 2009, the demonstration project involved five different Canadian cities, each chosen to focus on different needs (Aubry et al., 2015).

The research accompanying the demonstration ran until March 2013 and has provided the most comprehensive data on the effectiveness of HF to date. The MHCC implemented a pragmatic, randomised control field trial across the five sites over a period of 24 months, utilising a mixed methods design to measure outcomes. 2,148 individuals were recruited onto the study for two years of follow up, of these 1,158 received HF intervention with the others received treatment as usual (TAU) (Aubry et al., 2015).

Supporting findings from the 'Pathways' evaluations, positive outcomes were achieved in relation to housing stability, participant rated quality of life and observer rated community functioning. Additionally, the study also found that outcomes were more positive in cities that operated most closely to the standards and principles of the original Pathways HF. As in other studies, outcomes related to substance misuse and mental health were not better in HF than they were for the TAU cohort. Aubry et al. (2015) relate the parallel improvements across both intervention types to the similar services accessed by each cohort.

Clients with the highest needs: The Limits of Housing First?

There were a number of participants in the study (around 13%) for whom HF did not bring its core outcome measure, housing stability. The group tended to have longer histories of homelessness, more connection to street based social networks, lower educational attainment, more severe mental health issues and indication of greater cognitive impairment (Aubry et al., 2015). However, analysis by Volk et al. (2015) identified that many of these variables did not emerge as statistically significant predictors for housing stability. The authors did concede that longer cumulative time spent homeless and greater connection to street based social networks warranted further investigation. In particular, the ability to disengage from these networks. It is important to note that this analysis focused on predictors for remaining stably housed, as opposed to other outcomes. Nevertheless, these findings do support the presence of a strong and binding homeless culture that can hinder progression into mainstream housing and community functioning (Ravenhill, 2012).

Europe

In December 2010, the Jury for the European Consensus Conference on Homelessness, recommended that 'housing-led' approaches were the most effective solution for homelessness and that the different forms of HF were good examples of these 'housing-led' services. Evidence was emerging from a range of HF pilots in European cities, the first of which by Discus Housing in Amsterdam (Busch-Geertsema, 2013). Many other HF and Housing led projects were piloted throughout 2006 - 2014 with a range of specific support needs including diagnosed psychiatric needs (Lisbon), high levels of addiction and poly drug use (Glasgow) and even clearance of a particular forest area in Budapest (Busch-Geertsema, 2013). The HF Europe project facilitated coordination between these cities with funding under the PROGRESS programme from August 2011 to July 2013 (Busch-Geertsema, 2013). The programme sought to enable evaluation and

mutual learning between five test sites (Amsterdam, Budapest, Copenhagen, Glasgow and Lisbon). Information sharing took place across five other sites that were planning to implement HF projects (Dublin, Gent, Gothenburg, Helsinki and Vienna).

All of the above projects except Budapest demonstrated favourable outcomes, although Budapest was widely recognised as not having fidelity to a HF approach². Other models did not operate the same approach as 'Pathways HF' and were instead in keeping 'communal' and 'housing first light' services identified by Pleace (2011). Overall, the services demonstrated positive outcomes for housing retention, user satisfaction and quality of life. There were more mixed and less definitive outcomes around substance misuse and mental health. Evaluations highlighted limited outcomes around overcoming worklessness, financial issues and loneliness.

Evidence from the HF Europe project led to a number of national demonstration projects. Most recently the HABITAT programme in Spain, HF Italy, HF Belgium, the Danish National Homelessness Strategy, and Chez Soi D'Abord in France have all reported favourable outcomes in comparison with 'treatment as usual' with varying levels of supporting evidence. European level reviews (Busch Geertsema, 2013; Pleace, 2012; Pleace, 2016) coordinated by the European Observatory on Homelessness (FEANTSA) have provided a foundation of evidence which has led to several EU Member States, including Denmark, Belgium, Finland, France, Ireland and Sweden putting HF at the centre of their national homelessness strategies (Pleace, 2011; Pleace, 2016; Pleace, Culhane, Granfelt, & Knutagård, 2015). High levels of social protection in Denmark and Finland in particular mean that homelessness is often most associated with high needs individuals. Therefore, a HF approach is particularly appropriate to the types of people who become homeless in these countries.

² Hungary has been identified as a country with a particularly hostile approach to homeless people more generally, see Missetics (2013).

The Danish HF programme and the French Chez Soi D'Abord programme are the most developed and coordinated experimentation projects in Europe. The French programme ran from 2011 – 2016. The randomised control trial that evaluated the experimentation project involves 705 people, with 353 people receiving HF services (Pleace, 2016). At 13 months, the project reported 80% tenancy sustainment rates as well as reductions in rough sleeping, hospitalisations, imprisonment and emergency accommodation use. However, longer-term outcomes around health, wellbeing and social integration were less clear.

The Danish national homelessness strategy, which ran from 2008 – 2013, targeted over 1000 people and was guided by the principle of providing 'housing first'. Three floating support interventions were utilised including ACT, ICM and Critical Time Intervention (CTI) for those with comparatively lower needs. The accompanying evaluation demonstrated very positive outcomes in relation to housing retention. However, the most recent evaluation highlights significant barriers to further expansion due to the lack of affordable and adequate housing (Benjaminsen et al., 2017). Outcomes relating to other areas such as substance use, physical and mental health problems, daily functions, financial situation and social networks were more mixed (Benjaminsen, 2013).

HF Belgium was again part of a national homelessness strategy. After two years, results around housing retention were very positive (86%) in comparison to treatment as usual (48%) (Housing First Belgium, 2016). Further, some positive outcomes were noted around social integration (with one in ten accessing work or training) and researcher observed stabilisation or improvement of health issues (Pleace, 2016). The Spanish HABITAT programme works with 38 people in Malaga, Barcelona and Madrid operating with a mix of social and privately rented housing and utilising an ICM approach. The programme has reported a housing retention rate of 100% as well as moderate improvements in ontological security, family relations and economic situation (Bernad, Yuncal, & Panadero, 2016). The Italian network for HF so far involves 28 projects

scattered across 10 regions of Italy. However, without national government funding or coordination, and within a fragmented welfare regime the responsibility has largely fallen to the implementing charities to coordinate and evaluate.

Although much evidence still emanates from a North American context (Woodhall-Melnik & Dunn, 2015) there is growing evidence of effectiveness in a European context. European implementations have also provided evidence that the model can be applied in different welfare regimes, including those with minimal support (Mediterranean regimes) to those with high levels of support (Social democratic regimes in central European and Scandinavian countries) (Esping-Andersen, 2013, Fitzpartick & Stephens, 2014).

Nevertheless, there are still questions about the effectiveness of HF in weaker welfare state structures. Ultimately, differences in scale and methodological approach make comparisons of outcomes across different contexts difficult. With the aim of facilitating a coordinated European evidence based approach to HF, Pleace (2016) has recently designed the 'Housing First Europe' guide. This has aided in collating the evidence base emerging from widespread adoption across a range of different contexts in mainland Europe. However, it is once again worth noting that the evidence base demonstrates successful outcomes only in a narrow definition of housing retention, service costs and service engagement, with longer-term, recovery orientated outcomes less clear.

HF has moved beyond its origins as a model of support for a particularly challenging sub set of the homeless population, incorporating increasingly diverse housing and support types. The elements retained are the general principles of HF. As a result, Pleace et al. (2015) have claimed that HF has shifted from a perscribed model of support, to a service philosophy. Section 2.7 interrogates these principles, positing that they are representative of current trends in mental health and addiction recovery agendas. Before this, it is worth highlighting the small number of studies which have been explicitly concerned with recovery in HF.

2.6.3: Beyond Housing: Recovery in Housing First

As evidenced in previous sections of this chapter, the majority of HF studies have been large scale and quantitatively orientated, exploring change in comparison to 'treatment as usual'. However, in recent years a small number of studies have looked specifically at trajectories of recovery in HF, using qualitative methods.

As part of the Canadian 'Chez Soi' Implementation, longitudinal narrative methods were used to identify trajectories of recovery in HF and 'treatment as usual' (Nelson et al. 2015; Patterson, Rezansoff, Currie, & Somers, 2013) used longitudinal, narrative data to identify trajectories of recovery in HF. The researchers compared participants' narratives at baseline and 18 months to establish change.

Across all sites, 61% of participants described a positive life course since the study began, 31% reported a mixed life course and just 8% reported a negative life course (Nelson et al., 2015). In treatment as usual, the distribution of trajectories across the cohort was much more even with 28% reporting a positive life course, 36% reporting a mixed life course and 36% reporting a negative life course.

Stable housing and having subjectively positive social contacts were key factors behind positive trajectories across both cohorts. Subjective notions of increased control over substance misuse and the developing valued social roles were also important. In direct contrast, negative social contacts or social isolation as well as continued substance misuse were reported as contributing factors to negative trajectories, in turn, these factors also brought about feelings of hopelessness (Aubry et al., 2015; Nelson et al., 2015).

In a separate publication that focused on one particular implementation in British Columbia, Patterson et al. (2013) reported that positive trajectories were associated with good quality, stable housing, greater social support, and a willingness to self-reflect. Negative, neutral, and mixed trajectories were characterised by hopelessness, perceived

failures, and loss. In summary, these studies suggest an important role for local social networks in determining clients' capacity to achieve outcomes.

Padgett, Smith, Choy-Brown, Tiderington, and Mercado (2016) measured trajectories of recovery from mental health over the same time period but through four waves of mixed method data collection. Of 38 participants, the authors found that most participants had no significant change, with eight experiencing a positive trajectory, and seven a negative trajectory. As in the Canadian implementation, social relationships were an important mediating factor in both positive and negative trajectories, as was engagement in meaningful activities.

Henwood, Derejko, Couture, and Padgett (2015) used Maslow's hierarchy as a theoretical framework to compare the experiences of HF, and TAU clients. They found that qualitative findings revealed a complex relationship between basic needs, goal setting and self-actualisation. Ultimately, the authors argue that HF provided a better foundation and opportunity for basic needs to be met, but both cohorts generally struggled to actualise longer-term goals related to, for example, building relationships and finding employment. A key conclusion was the need for a recovery orientated system in mental health in which 'client centred' approaches are given further consideration, particularly around the limited resources available to those in poverty to pursue their longer term outcomes.

In the UK, Johnsen (2014) explored recovery trajectories amongst 22 participants in a HF implementation in Glasgow at two time points at the beginning and end of a 3 year pilot. This study explored progress beyond mental health, incorporating a range of different outcome domains. Johnsen categorised participants into three different trajectories: '*sustained positive change*', '*fluctuating experiences*', and '*little observable change*'. Half of participants experienced 'sustained positive change', with reduced or stabilised substance misuse, improvements in mental and physical health, and strengthened social networks. A quarter of participants experienced 'fluctuating

experiences' with stability interrupted by periods of 'slips', which impacted their ability to manage their tenancy. Those who retained contact with social networks developed in homeless settings were at greater risk of relapse. The remaining participants experienced little evidence of change, generally engaging in the same behaviours as they had done before and facing ongoing challenges in maintaining their tenancies.

Each of these studies demonstrate the variable nature of participants' capacity to pursue recovery orientated outcomes. Some highlight the importance of environmental factors such as social support, but also personal factors such as a sense of hopelessness in determining trajectories. However, there is no detailed enquiry into how participants' life histories have contributed to their trajectories in HF. In turn, environmental context is considered, but biographical context is not. As participants' needs have resulted from life times of exclusion, this would seem to be an important area of enquiry.

The next section explores how each of the HF principles, retained throughout implementations are designed to support in the recovery from exclusion and complex needs.

2.7: Housing First Principles

The principles of HF are at its core, differentiating the model of housing and support from traditional responses. However, there has been little attention paid to the rationale of each principle or the contingent relationships between them. In their review of HF literature, Raitakari and Juhila (2015) highlight the need to unpack "the dilemmas of translating abstract principles into everyday practices and interactions" (p.173). Doing so can have a valuable role in deconstructing HF discourses which have been widely accepted with little critical interrogation.

In addition, the authors posit that the HF literature pays little attention to relevant research in other fields such as mental health or substance misuse. The following sections begin to overcome some of these concerns by briefly deconstructing each principle and situating them within housing, mental health and addiction recovery, and

offending desistance literature. Cornes Manthorpe, Joly, & O'Halloran (2014) follow Davidson and White (2007) in positioning 'recovery' as a key concept in organising and delivering multi-disciplinary support for MEH adults. Cornes et al. argue that the principles of HF represent a more personalised and inclusive practice model which can support recovery for these individuals.

The principle of client choice and control is then identified as a principle which requires further investigation for three key reasons. Firstly, because this principle permeates all other principles of HF. Secondly, because this principle is the key mechanism through which longer term, recovery orientated outcomes are pursued. Thirdly, and on a related note, because this principle conflicts with critical accounts in social policy literature which posit that socially disadvantaged groups (of which MEH adults are one) are less able to utilise the mechanism of choice to gain control and achieve positive outcomes.

2.7.1: Immediate, Independent, Scattered Site Housing

The provision of immediate, independent housing 'scattered' in the community reflects the view that situating individual's recovery in the community enables more freedom and prevents barriers associated to institutionalisation and social disaffiliation (Goodman, Saxe, & Harvey, 1991; Lamb, 1993; Ridgway & Zippel, 1990). In turn, studies have demonstrated that independent housing can foster community integration and act as a foundation for the pursuit of recovery (Martins, Ornelas, & Silva, 2016; Ornelas, Martins, Zilhão, & Duarte, 2014; Yanos, Barrow, & Tsemberis, 2004). This differentiates HF from a 'treatment first' philosophy where independent housing is the end goal, achieved only after the individual is deemed 'housing ready'.

UK literature on the meaning of home provides a useful source for understanding how housing can act as a foundation for other outcomes. King (2003) posited that people must have a place to 'be' and housing provides a space from which individuals can attain higher functions. Clapham (2005) supports King's perspective, noting that housing has

become a means to an end rather than an end in itself. Housing provides the ontological security required to enable wider goals in relation to wellbeing, and social relations. More recently, Clapham (2010) drew together the key aspects of the literature on the meaning of home. He notes that a home generates security, positive meaning and self-esteem. In subsequent work, Clapham (2011) cites Gieryn (2002) to contend that 'buildings stabilise social life', offering a place for individuals to define themselves and pursue their own priorities. This conception fits well with the HF model, which positions housing as the foundation for the pursuit of other goals. However, Clapham (2011) also recognises that the physical structure of accommodation can constrain meaning and purpose. As such, having a building in which to reside is not necessarily constitutive of a foundation from which to pursue wider priorities. With reference to HF, Quilgars and Pleace (2016) argue that there is a need to look critically at the extent to which HF can deliver social integration, moving beyond the successes in housing sustainment and identifying what is needed to enhance people's lives in the long term.

For example, the destination communities of HF clients are an important consideration for facilitating longer-term outcomes. Although there is still debate about how much contact anyone has with the people that they live geographically close to (Boyce, 2006). Evidence from recovery and desistance literature highlight that communities (and their constituent social networks) can facilitate or constrain recovery and desistance processes (Bradshaw, Armour, & Roseborough, 2007; Laudet, Magura, Vogel, & Knight, 2000; Laudet & White 2008; Mezzina, Borg, Marin, Topor, & Sells, 2006; Topor et al., 2006; Tew et al., 2011). In particular, situating recovery in areas with high levels of drug use and crime or close to social networks who continue to engage in these behaviours can act as significant hindrances to recovery and desistance (Webster, MacDonald, & Simpson, 2006; Kirk, 2012; Dingle, Stark, Cruwys, & Best, 2015) (also see section 2.6.2).

2.7.2: Harm Reduction Approach to Substance Use

In drug treatment, a 'harm reduction' philosophy emerged in response to issues with abstinence based approaches to substance misuse 1960s and 70s. In the mid-1980s, these alternatives began to be referred to collectively as 'risk reduction', 'harm reduction' and 'harm minimization' (Roe, 2005). They were based on a recognition that responses to drug use which emphasised abstinence based approaches may be setting individuals up to fail by not taking account of the intersectionality of drug users issues. These changes represented a shift to a pragmatic and individualised approach, emphasising change as a gradual process requiring open-ended support, another key principle of HF (see section 2.7.3). Recovery paradigms in substance use follow those in mental health literature to promote the central role of the service user and of unique and personal journeys (Neale et al., 2014). Concentrating on reducing harm rather than achieving and maintaining abstinence may mitigate the stigmatisation and criminalisation many drug users face (Buchanan, 2000; Taylor, Buchanan, & Ayres, 2016). In turn, enabling a more meaningful dialogue and support to reduce harmful drug use overall. Consequently, a harm reduction philosophy is contingent upon a respect for client choice, autonomy and control.

As well as being inherently personal, harm reduction practices are situated in the environment in which they operate. Rhodes (2009) characterises harm reduction as being contingent on 'risk environments' and 'enabling environments'. Harm reduction can be understood as a matter of contingent causation, as reducing harm relies heavily on separation from social situations and environments that carry greater risk of drug use for the individual. In turn, a successful harm reduction intervention is also reliant upon the presence of an enabling environment, which acts to support and encourage harm reduction.

2.7.3: Open Ended Support

Across addiction, offending, and mental health literature, processes of recovery are conceptualised as 'on going journeys', taking considerable time and effort and with no promise of an end (Padgett et al., 2016). In the case of substance abuse, White and Kelly (2010) have argued that addiction should not be treated in time limited 'emergency room type' interventions, but rather like chronic health disorders, with continuing care and follow up. As those facing MEH commonly experience mental health, substance abuse and offending issues concurrently, recovery journeys are likely to be even more complex (Cornes et al., 2014; Van Roeyen, Anderson, Vanderplasschen, Colman, Vander Laenen, 2016).

White (2007) highlights that recovery from substance abuse can follow a periodical process, or can be transformational, with a single event enabling a shift to abstinence or a resolution of the problems associated to substance use. However, in most cases 'recovery' is a lengthy and non-linear process (Laudet & White, 2010).

White's account has parallels with the pathways approach in homelessness research (Clapham, 2003)³. Although broad trends can be identified, each highlight that these processes are unique to each individual, requiring an approach that enables the client to have control over the journey (Davidson, 2005; Cornes et al., 2014; Neale et al., 2014). For MEH adults seeking recovery or desistance we can understand these processes as involving intertemporal choices (choices that have consequences that play out over time) that can support, hinder or halt progress (Berns, Laibson, & Loewenstein, 2007). A process of recovery or desistance begins with an individual deciding to seek change in their lives. To maintain that process, the individual must also negotiate a range of choices over an undefinable period. Making these choices constitutes a significant challenge, particularly in the context of social and economic exclusion. The principle of

³ The 'pathways' approach is discussed in more detail in section 3.6.

open-ended support encourages the service to recognise these challenges and continue to work with clients for as long as required to achieve and maintain progress.

For case managers, negotiating how to inform and support clients' choices is dependent on the personal capabilities of both client and case manager. The line between advice and coercion may be a difficult one to negotiate, particularly when the support worker believes the client is following a trajectory that is harmful to their recovery.

2.7.4: Separation of Housing and Treatment

The separation of housing and treatment allows clients to refuse treatment or support with no detrimental impact on their tenancy (Tsemberis et al., 2004). In theory, this 'right to refuse' redistributes power from the service provider to the client by removing the possibility of eviction. In turn, the clients' choices must be accepted or at least reasoned with rather than refused based on contradiction of accommodation or support conditions. From one perspective, this releases clients' from paternalistic support, instead providing foundation for clients to pursue a greater sense of control over their lives. From another, the principle forces clients to become reluctant agents of change in their lives.

The first perspective is arguably more popular in liberal societies. Enabling people to have greater control over their own lives is widely accepted as desirable in humanitarian terms (Padgett et al., 2006). However, separating housing and treatment may not necessarily enable greater control as instead; other forms of legitimacy for authority may emerge. Keat, Whiteley, and Abercrombie (1994) outline four ways in which this can occur: deference, taboo, expertise, and meaning. Keat, et al. argue that by maintaining authority, control can 'reasonably' be restricted through professional structures. Providers define the context for choices (meaning) and are able to set boundaries on control due to fears that giving certain groups too much control will be dangerous (taboo). In reference to HF, Löfstrand and Juhila (2012) emphasise this by noting 'non-negotiable' requirements of Pathways HF such as pre-arranged tenancy visits. Further, clients may

defer choices due to a lack of personal motivation or confidence (deference), or due to the perceived trustworthiness and expertise of the professional (expertise).

This leads to the question of whether more control for clients leads to better outcomes. This question closely aligns with clients' capacity to be agents of change in their lives. Clients must understand their own needs, desires, capabilities and the potential outcomes of their actions. They must also be motivated to discuss these and be open to influence from support workers without deferring responsibility. In this way, we can understand that assumptions of a rational consumer are present in the HF philosophy, as discussed further in the following section.

2.7.5: Client led approach emphasising choice and control

A commitment to choice and control permeates and influences all other elements of the model. As in supportive housing models, HF clients are afforded choice and control over "where they live, how they live, and the professional support that they receive" (Carling, 1995 c. Nelson et al., 2007: 89). HF gives clients choice and control over material resources through the provision of immediate, independent housing. The principle of 'harm reduction' removes any requirements of abstinence, giving clients' more autonomy over their substance use. The 'separation of housing and treatment' gives clients greater control over their housing and support by not making one contingent on the other. Lastly, the principle of 'open-ended support' allows clients to pursue outcomes at their own pace, rather than adhering to a timetable set out by support providers. All of these principles remove conditions placed on clients in 'treatment first' models, offering them greater autonomy and control. However, offering greater control to clients also means that they have greater responsibility for guiding their own recovery, through their choices.

Whereas traditional 'treatment first' approaches take control away from the client and aim to 'treat and teach' clients; HF approaches favour a consumer driven approach, framing the client as 'chooser', guiding their own personal trajectory. Woodhall-Melnik and

Dunn (2015: p. 288) summarised the rationale behind the principle of choice and control well with reference to Padgett et al. (2006):

“Choice over restriction and empowerment over compliance deserve consideration as not only effective but humane. It is suggested that requiring housing readiness removes a person’s right to determine his or her own clinical treatment and can lead to failure for those who are unwilling or unable to remain sober or participate in mental health treatment.”

As highlighted by Padgett et al. (2006) there is some evidence to suggest that choice is not only humane, but also effective. Tsemberis et al. (2004) demonstrated that consumers of HF services felt more choice than in linear support models. Further, Greenwood, Schaefer-McDaniel, Winkel, and Tsemberis (2005) provided evidence to suggest that perceived choice partially mediated through a sense of personal mastery is related to psychiatric outcomes for homeless individuals⁴. Having some degree of control over housing location and quality has been positively correlated to independent functioning (Martins et al., 2016). These studies demonstrate that greater choice can enable individuals to perceive a greater sense of personal mastery, which can lead to a greater sense of subjective wellbeing. These findings are replicated in studies exploring supportive housing more generally (Srebnik, Livingston, Gordon, & King, 1996; Nelson et al., 2007) and social policy accounts (Le Grand, 2009). Each argue that choice is positive in and of itself, enabling a greater sense of control over one’s life and a greater sense of participation in society (Le Grand, 2005; 2009). This assumption has been demonstrated by academics exploring the impact of perceived choice on wellbeing (Dolan, Layard, & Metcalfe, 2011; Dolan, Peasgood, & White, 2008).

Where research is lacking is in investigating the relationship between the principle of choice and control, and achieving other recovery orientated outcomes. Offering choice

⁴ However, evidence outlined in section 4.2.4 of this thesis suggests that the scale used to measure personal mastery may be compromised in its ability to do so.

and control over housing, support, and behaviour may enable higher subjective wellbeing but these are also intertemporal choices which more broadly inform the recovery trajectories and lives of clients (Berns et al., 2007). Choice is the mechanism by which clients utilise control over their housing, support and behaviour in order to guide their recovery.

As the 'chooser' is a MEH adult, choice and control are noted as being the most radical elements of the model as offering a high degree of choice to chronically homeless individuals is contrary to the cultural imperative in the western world (Löfstrand & Juhila, 2012; Parsons, 2002; Pleace, 2011). Short term gains in subjective mastery and wellbeing are tenuous if clients' choices lead to relapse, eviction or other negative consequences. There is a general paucity of evidence exploring whether the reality of making choices diminishes the positive effect of perceived choice, particularly when choices are restricted or bring negative outcomes.

Studies exploring choice in HF have to this point have been based on psychometric tests which identify correlation between factors without interrogating the nuanced causational pathways and the conditions upon which these pathways are contingent. For example, Greenwood et al. (2005:234) note that research is needed into the impact of coercion on choice and limitations on choice in homeless support models.

The most overt critique of consumer choice in HF comes from Löfstrand and Juhila (2012). Through a Foucauldian discourse analysis of HF literature they argued that HF is in keeping with an advanced liberalist method of controlling subjects, aiming to "render people as self-responsible as possible" (Löfstrand & Juhila, 2012: 64). The authors argument echoes a chorus of critical voices suggesting that the use of 'consumer type choices' as a means of participation in neoliberal society systematically privileges the forms of cultural and social capital typical of the middle classes (Rose & Miller, 2008; Greve, 2011). Holland and Thomson (2009: 452) summarise these critiques, postulating:

“Although much of the rhetoric of neo-liberal governments and late modern social theory suggests that the structuring patterns of the past (class, gender, race) are giving way to increasingly individualised biographical patterns shaped by choice, in practice life chances continue to be shaped profoundly by familiar inequalities, albeit in new ways. Yet forms of government increasingly put the individual on the spot; it is the individual who has to make the right choices about work, health, employment and intimate life, with the project of self emerging as the medium through which opportunity and resources are mediated.”

HF, and other ‘client led’ approaches arguably replicate this ‘project of self’. The client is required to be the agent of change, directing choices about housing, support, and behaviour towards their own idea of a ‘recovered self’. On a personal level, Fitzpatrick and her colleagues have shown that the support needs of MEH adults in the UK differ across the population, as does the extent to which they have engaged with mainstream activities such as education and employment (Fitzpatrick et al., 2012; Fitzpatrick & Bramley, 2015). As a result, variation is likely in each clients’ ability to overcome needs, and pursue activities representative of social and economic inclusion.

On an environmental level, HF certainly increases the resources and opportunities available to clients by enabling them to access independent accommodation. However, as recognised by the model’s founder, clients still generally move from homelessness to material poverty (Tsemberis, 2010). In turn, HF operates in a range of different social, economic, and political contexts. As a result, there are broad differences in, for example, welfare provision, housing markets, treatment services, education, and employment opportunities available to clients. All of which determine the options available for clients to choose from. A number of studies have highlighted this disconnect between an individualised focus on choice in public policy and broader issues which can hinder the intended benefits of offering ‘choice’. In particular, inequity in the capacity to utilise choice

and imbalanced power relations can hinder the perceived benefits of choice (Clarke, Newman & Westmarland, 2008; Stevens et al., 2011)

Therefore, Löfstrand and Juhila's (2012) critique raises a number of important questions about just how humane and effective choice is in HF. Chapter 3 explores these questions further, illuminating the personal and environmental factors which affect an individual's capacity for choice. This chapter concludes by exploring the specific context in which participants in this study will make choices, and in which the HF service will operate.

2.8 - UK and England

As Raitakari and Juhila (2015: 173) note:

“Since HF is not implemented in a vacuum, it is also vital to examine further what contemporary policy trends in relation to public services (such as active and responsible citizenship discourse) mean for the implementation of HF in different contexts and for the life conditions of the people with severe mental and substance abuse difficulties.”

Consequently, this section explores the national and local context in which the Newcastle HF service operates. Before doing so, it is useful to outline the UK evidence base for adoption of HF as a model for responding to MEH.

Homeless people with complex support needs have become a policy priority in the UK in recent years (Johnsen & Teixeira, 2012). Existing service interventions have consistently failed in engaging and supporting these individuals, leaving them at risk of repeat homelessness and significant social exclusion (Cabinet Office, 2007; MEAM, 2009 c. Johnsen & Teixeira, 2012).

HF is a fitting political solution to these issues, demonstrating un-paralleled success in accommodating homeless individuals with complex needs. However, Johnsen and Teixeira's (2012) study of UK service provider and policy maker perceptions

suggested that the model had failed to gain widespread adoption with many service providers noting that they were 'doing it already'. Although linear models of support are still dominant in the UK, floating support schemes and multi-agency working are also prevalent (Cloke et al., 2010; Fitzpatrick, Pawson, Bramley, & Wilcox, 2011). Since the early 1990's and the Rough Sleeper Initiative (RSI) homeless individuals have been housed in self-contained accommodation with relative success. Busch-Geertsema (2002) demonstrates that of around 5,000 permanent tenancies for former rough sleepers created in London under the RSI between 1990 and 1997, only 16 per cent failed.

Even amidst these barriers, HF or 'housing led' approaches have gained traction in the UK in recent years. The Centre for Social Justice (2017) recently called on the UK government to endorse HF as the main means of housing and supporting rough sleepers and homeless people more broadly. This rise in HF projects has coincided with the creation of the Homeless Transition fund created by the Department for Communities and Local Government and specifically allocated by Homeless Link to non-profit organisations working to support rough sleepers, so far it has funded five services in England (Bretherton & Pleace, 2015).

Turning Point Scotland established the first UK HF pilot in Glasgow in 2010. Although homelessness legislation in Scotland differs to England, the Glasgow pilot did show the model's success in delivering support to a particularly difficult group in a UK context, without complete fidelity to the original Pathways model. The accompanying evaluation (described in more detail in section 2.6.3) demonstrated positive outcomes around housing retention, service engagement and physical health, as well as mixed outcomes around substance misuse and mental health (Johnsen, 2014).

More recently, Bretherton and Pleace (2015) conducted the only multi-site evaluation of HF services in England. Their observational study collected data from 60 service users across nine services using an anonymised outcomes form, supplemented with 23 service user interviews. They found generally favourable outcomes for HF around

housing retention and moderate outcomes associated to physical health. However, in line with other implementations, outcomes elsewhere were less clear within the short timescale of the study.

With support from Pleace, and HF providers across England, Homeless Link (2016) produced a set of HF principles relevant for an English context. These were:

- People have a right to a home
- Flexible support is provided for as long as it is needed
- Housing and support are separated
- Individuals have choice and control
- An active engagement approach is used
- The service is based on people's strengths, goals, and aspirations
- A harm reduction approach is used

The principles closely align to those outlined in section 2.7, as well as those in the original PHF implementation. The inclusion of a 'strengths based' approach is not explicitly noted in other sets of principles, but is implicit in the 'recovery orientated' nature of the HF principles, and model more generally. The 'capabilities' approach to outcome measurement used in this study (see section 3.5.2) can offer some indication of the extent to which a 'strengths based' approach is beneficial for all participants.

Overall, there is a general paucity of evidence on the effectiveness of HF in an English context. This is particularly true in relation to the medium to longer-term trajectories of HF clients.

2.8.1: English Policy Context

As highlighted by Raitakari and Juhila (2015), it is vital to explore the policy context in which HF operates. This study is more specifically concerned with how the mechanism of choice contributes to longer term outcomes, beyond housing retention. A wealth of

literature exists on the mechanism of choice under New Labour. However, since 2010, social policy literature has focused more on austerity and welfare reform. A trend running through each of these policy agendas is the balance of personal choice, and personal responsibility.

A central tenet of New Labour's 'Third Way' was the link between 'right and responsibilities' (Dwyer, 2004). Underpinned by Giddens' notion of a 'social investment state' aimed to overcome familiar inequalities by redistributing opportunities, rather than wealth (Dwyer, 2010). In homelessness provision, New Labour's Rough Sleepers Unit emphasised the importance of work as a means of tackling social exclusion for homeless people. Since 2010, increased pressure has been placed on welfare recipients to pursue employment (Etherington & Daguerre, 2015). Individuals are 'empowered' to take control of their own lives but also responsible for the consequences if in doing so they make the 'wrong' choices. These consequences have arguably become increasingly punitive around welfare conditionality and behaviours deemed troublesome and anti-social. The alternative for many of those deemed not to be fulfilling the conditions of their welfare receipt are sanctions, leading to a reduction in resources available to make subjectively beneficial choices and to become actively included (Webster, 2014; Wright, 2012).

In broader terms, Bradshaw, Glendinning, Maynard and Bennett (2015) conclude that fiscal consolidation rather than social investment has been the dominant influence since 2010, with resources distributed away from those on low incomes. Peck (2012: 626) uses the more common term of 'austerity' in discussing the shift in the neoliberal script post 2008, emphasising that fiscal consolidation is most often targeted on local authorities and on the most vulnerable, both socially and spatially. Research suggests cuts in services essential to the recovery of individuals facing MEH, including cuts to 40% of mental health services through 2013/14 – 2014/15 (Kings Fund, 2015).

Peck's argument holds true for those who are most vulnerable in society, with wide ranging welfare reform measures since 2010. As this study is concerned with individuals

moving into the PRS, perhaps the most relevant welfare reform measures are reductions in Local Housing Allowance (LHA) rates (Beatty & Fothergill, 2014; Gibb, Sprigings, Wright, & McNulty, 2014). Reductions since 2011 have restricted the amount of money available for housing benefit recipients accessing the private rented sector (PRS). Alongside this cut, the Localism Act (2011) provided new powers to local authorities to discharge the statutory homeless duty to the PRS. As a result, these individuals are placed in market based tenancies which offer limited security of tenure, evidenced in evictions from the PRS becoming the biggest cause of homelessness in the UK (Fitzpatrick, Pawson, Bramley, Wilcox, & Watts, 2017). Further, the most recent homeless monitor for England has identified that one in two local authorities in England find it very difficult to place homeless individuals in the PRS (Fitzpatrick et al., 2017). A recent Shelter report identified significant barriers for housing benefit recipients in trying to access the PRS, related to affordability as well as landlords being unwilling to let to them (Spurr, 2017). As a result, HF clients are able to exercise less consumer choice over their housing, as well as facing a higher level of responsibility for their choice due to the generally less secure PRS.

As such, rather than simply accepting the rhetoric of greater choice, it is important to investigate critically the extent to which choice is actually available to vulnerable individuals within the wider policy context. This is even more pertinent in the current UK context of welfare provision in which the responsibility for making 'bad' choices may bring damaging consequences for the individual. With their implicit focus on choice, HF services are able to offer wider insight into the ability of marginalised groups to exercise choice by concentrating on one of the most excluded and vulnerable groups in British society (Fitzpatrick et al., 2011).

2.8.2 - Housing First Newcastle

Newcastle's homelessness review states that during the last 10 years homelessness in Newcastle has been more the product of poverty and vulnerability than

of a housing shortage (NCC, 2013). However, they acknowledge that homelessness still exists and is very distressing for those affected and the risk appears to be growing in terms of individual vulnerability and housing shortages due in part to the Government's welfare reforms (Harding et al., 2013). In Newcastle, austerity has manifested in a £223 million of cuts in central government funding from 2010 – 16 (Newcastle City Council, 2016). Beatty and Forthergill (2014) have also identified Newcastle as amongst the local authorities that have faced the greatest overall financial loss arising from welfare reform.

Amongst a context of rising levels of rough sleeping and statutory homelessness nationally and across most core cities (Harding et al., 2013), Newcastle had seen a reduction in rough sleeping from 2011 – 2013. This may be associated with the council's commitment to end rough sleeping in the city. However, rough sleeping in Newcastle no longer bucks national trends, instead seeing small incremental increases from 2013 – 2015 before a drop in 2016 (ONS, 2016a). NCC conceded that they must do more to meet the needs of the more excluded individuals in the city (NCC, 2014). To meet the needs of MEH adults in the city, the council issued a 'Multiple Exclusion Service' contract through competitive tendering process won by Changing Lives in June 2014. The contract includes the provision of outreach services for multiply excluded individuals and rough sleepers, including daily counts; the running of a day centre and a HF service of 60 units (NCC, 2014). Prior to this, Changing Lives had begun a pilot of HF in Newcastle in early 2012, funded through the Homeless Transition Fund.

The Multiple Exclusion service focuses on a relatively small group of individuals with the initial target of 60 households. The service is legitimised in reference to the disproportionate issues this group present in terms of lack of engagement, complex health and addiction issues and behavioural problems. At the point of recruiting participants to the study the HF service had been operating for 13 months. 42 clients were being supported by the service, with 34 of these in HF accommodation.

The service contract recognises the wider focus on ‘active inclusion’ in Newcastle, by focusing on a broad range of outcomes associated to achieving a subjectively desirable, meaningful, and sustainable life. The outcomes desired by Newcastle City Council are outlined in table 2.1, below. Although categorised in a particular way, many of these outcomes are in line with general service outcomes for this group (Pleace & Wallace, 2011; Pleace, 2016).

Table 2.1: Desired outcome areas outlined in the Newcastle Multiple Exclusion Service Contract

<u>Outcome Area</u>	<u>Definition</u>
‘Economic Wellbeing’	Refers to securing income, including around benefits as well as reducing debt.
‘Enjoy and Achieve’	Refers to engagement in meaningful activities such as education, volunteering and employment. This outcome category also refers to (re) engaging with positive social networks such as family, friends or other services.
‘Be Healthy’	Incorporates widely defined outcomes around physical health, mental health, wellbeing, substance misuse, abuse and exploitation.
‘Stay Safe’	Generally refers to adhering to legal and social norms set out in the tenancy agreement and legislation. As such, the service aims to prevent clients from engaging in or being victims of crime. Self harm is also noted here, although it may have a closer relationship with ‘being healthy’.
‘Make a Positive Contribution and Improve Wellbeing’	Explicitly notes greater choice and control over support and treatment as an outcome. This also refers to clients engaging on a wider level in their destination community.

The principles guiding HFN are largely in keeping with accepted principles of a HF approach. Table 2.2 highlights these similarities by comparing key HF principles with those outlined in the Newcastle Service Contract.

Table 2.2: A comparison of key Housing First principles and principles outlined in the Newcastle Service Contract

<u>Key Housing First Principle</u>	<u>Principle in Newcastle Service Contract</u>
Immediate, independent, scattered site Housing with no requirement of 'housing readiness'	[Housing is offered to] clients who are not 'tenancy ready' and/or stuck in a cycle of homelessness (including rough sleeping or hostels) – prison or hospital, and living a chaotic street lifestyle
Harm Reduction Approach	The client is not required to address their drug or alcohol use or access other services other than meeting the terms of their tenancy.
Separation of Housing and Treatment	The client is not required to address their drug or alcohol use or access other services other than meeting the terms of their tenancy.
Client led approach emphasising choice and control	Clients must have choice and control over where they live, that is as much choice as possible within constraints of market. People are housed in dispersed properties rather than being clustered in one building or small geographical area. Support is highly personalised and directed by the client.
Open Ended Support	Intensive support is offered to meet the terms of the tenancy and other needs which the client wishes to address. Support is highly personalised and directed by the client.

In line with the original Pathways model, the service source independent scattered site housing primarily through the PRS. This is mainly due to the high incidence of rent arrears in social housing among many MEH adults in the city, excluding them from this form of accommodation. However, PRS accommodation was appropriate in New York, it is perhaps less appropriate in Newcastle which has a relatively high level of social housing. The limited security offered to tenants by the PRS may be one key reason why

evictions are particularly common. In a sector that contributes so much to causing homelessness, the possibility of generating the security and stability required to pursue other goals is arguably restricted (Fitzpatrick et al., 2017).

In line with other implementations of HF in England, a case management support model is employed, replicating the ICM approach outlined in section 2.5. The role of these staff is to provide housing related support, signpost to other appropriate services, and provide the appropriate advice and support for clients to guide their trajectories towards subjectively desirable outcomes. Case managers' case loads consisted of both clients in HF accommodation, those who were rough sleeping and those in temporary accommodation. The rationale behind this was that case managers would support clients from rough sleeping or temporary accommodation into HF, providing consistent support throughout and building a relationship with clients. In the original 'pathways' implementation consumers would see their support worker at least 6 times a month. In Newcastle, the frequency and amount of appointments was determined according to the intensity of support required, and in collaboration with the client. However, in practice most participants in this study would still see their case manager at least once a week, and in some cases, up to five times a week.

As clients often have complex needs around mental and physical health, offending and addiction they require support from professionals operating in different disciplines, funded through different streams and government departments (Corney et al., 2014). Negotiating access to each of these external services can pose significant challenges for case managers (Drake, Mueser, Brunette, & McHugo, 2004; Priester et al., 2016). In turn, clients' capacity to achieve longer term, recovery and desistance orientated outcomes may be diminished.

2.9: Conclusion

This chapter reviewed the origins, philosophy, proliferation and evidence base associated of HF. In the course of this review, three areas of HF literature emerged, with each requiring further consideration.

The first gap centres on the question of what constitutes 'success' in HF. It is apparent across implementations that HF has demonstrated positive outcomes around perceived quality of life, community functioning, perceived choice, service satisfaction and particularly housing retention. Such outcomes have generally emerged from large scale and quantitatively orientated evaluations. In a range of contexts, these evaluations have demonstrated that HF delivers better outcomes when compared with treatment as usual. Nevertheless, the capacity of HF services to facilitate favourable outcomes associated with recovery from substance misuse, mental health, and offending desistance is less clear, as are engagement with meaningful activities and evidence of social and economic inclusion. As noted in the introduction to this thesis, this study does not seek to challenge the model's uniformly encouraging evidence base. However, it does seek to explore in greater depth the lived experiences of HF clients, as they pursue recovery-orientated outcomes. The subjective nature of recovery requires a smaller, more qualitatively orientated study.

A small number of studies have employed qualitative methods to explore recovery journeys in HF, with each demonstrating positive, yet varied trajectories for participants. These studies suggested that both personal and environmental factors play important roles in determining trajectories. In particular, social networks seem to play a prominent role in either facilitating or hindering recovery in HF. However, there is only very little detailed enquiry into the biographical factors which can influence participants' trajectories in HF. Such enquiry is particularly important when we consider that the findings from the Canadian demonstration project 'Chez Soi', which indicate that those with the most complex needs may face the greatest challenges in HF.

The second trend in HF literature centres on the lack of critical interrogation of the model's principles. These principles are at the core of the model, and have been widely retained and accepted with little critical interrogation. Section 2.7 deconstructed each principle, situating them within housing, mental health and addiction recovery, and offending desistance literature. It was argued that each of these principles are underpinned by a commitment to client choice and control.

Offering choice and control is deemed both humane and effective, with a number of studies relating perceived choice to improvements in subjective wellbeing. However, choice is also the mechanism by which clients are able to direct housing, support, and behaviour towards their subjective notion of recovery. At present, there has been very little detailed, qualitative enquiry into the clients lived experiences of making choices in HF. More broadly, only few studies have explored clients' capacity to choose their way to a 'recovered self' in HF. Achieving recovery is dependent on consistent behavioural change. Such behavioural change is in itself dependent on the capacities of clients to make intertemporal choices that enable trajectories towards longer-term outcomes, while also restricting behaviours that may impede this trajectory.

Such change is also dependent on the wider economic, social and political context in which clients' recovery journeys take place. This leads to the third gap in the HF literature; the lack of detailed enquiry into how HF operates in specific local contexts. As the model has proliferated across North America and Europe, questions of fidelity to the original Pathways implementation have become more prominent. In each new context, the model of housing and support has differed, while outcomes have remained broadly similar. HF is new in England, and detailed enquiry is needed into how the model operates in this context. This study is able to contribute to important questions for HF in England. Firstly, how is HF delivered in a wider context of welfare reform and austerity? Secondly, what are the benefits and challenges of sourcing housing through the PRS, within the English housing market? Thirdly, how effective is the single case manager model of

support, with mental health and substance misuse support provided through a 'signposting' approach?

In summary, rich, qualitative enquiry is required to identify how clients negotiate choices about recovery, and which factors impede or support their ability to do so. In particular, there is distinct lack of enquiry into the role of personal biographies in determining clients' ability to utilise the mechanism of choice to achieve recovery-orientated outcomes.

This study aims to provide such an enquiry, within the specific local context of Newcastle-upon-Tyne. The next chapter outlines the theoretical framework that informs the methods used to undertake this enquiry.

3: Understanding ‘Choice’ and ‘Success’ for MEH adults: A Situational Approach

3.1: Introduction

This chapter outlines the theoretical framework used in this study to examine the choices of MEH adults in HF. This allows interrogation of the effectiveness of ‘choice’ as a mechanism for enabling positive trajectories towards desirable outcomes and exploring which environmental and biographical factors affect clients’ ability to utilise ‘choice and control’ to achieve outcomes.

Perspectives around choice in HF vary between those who see it as both a humane and effective mechanism, and those who see it as a liberal method of passing responsibility from the service to the client. In homelessness literature more broadly, there is very little enquiry into individual choices. McNaughton Nicholls (2009) suggests this may be founded upon a desire to avoid pathologising people experiencing homelessness. However, in social policy literature a chorus of critical voices have accompanied the introduction of choice mechanisms in policy responses since 1980’s (Rose & Miller, 2008). These critiques broadly argue that choice mechanisms favour actors who have the capacity to act in a more rational and optimising manner, by societal standards. In doing so, they highlight inequities in the capacity to utilise the mechanism of choice, particularly among marginalised groups.

Section 3.3 interrogates the assumptions of rational, optimising actors that underpin the promotion of choice by exploring the broad literature on decision-making and rationality. In doing so, the assumptions of a rational actor model are quickly dispelled and instead a ‘bounded’ understanding of rationality is highlighted. Section 3.4 considers two recent approaches to understanding rationality and action: contextual rational action (Somerville & Bengtsson, 2002) and situational action theory (SAT) (Wikström, 2014). Each approach is broadly complementary in ontological perspective. Further, each place analytical focus on the interrelation between person, setting and time. However, the

situational framework offered by SAT provided a clearer and more substantive approach. In turn, providing a useful framework for understanding the complex decision-making processes of MEH adults. Section 3.5 covers the key components of a situational approach, based on Wikström's SAT (Wikström, 2004, 2005, 2014). In turn, assisting in our understanding of the factors that promote or impede recovery and desistance processes for MEH adults.

The remainder of the chapter is structured by the three key components of a situational approach; person, setting, and time. Section 3.5.2 explores 'the person' focusing primarily on the development of 'needs', 'preferences', and 'capabilities' relevant to pursuing recovery and desistance orientated outcomes in the context of HF. Section 3.5.3 then explores the role of 'setting'. Particular attention is paid to the influence of 'local social networks' of MEH adults as well as the broader 'opportunities', 'resources' and 'norms' which govern the choices of MEH adults. The role of time is implicit throughout the chapter, with more explicit discussion in section 3.6. 'Time' is understood as a theoretical lens through which the interaction between person and setting can be examined (Thomson, Holland, & Henderson, 2006).

Before outlining this theoretical framework, section 3.2 clarifies the choice's clients in HF face if they wish to pursue recovery, desistance and the more positive life these terms suggest.

3.2: Choices of MEH Adults in Housing First and Beyond

Before exploring the explanatory theory around choice, it is worth clarifying the type of choices clients in HF face, as well as the rationale behind the mechanism of choice.

As explained in Chapter 2, HF affords clients a high degree of choice over housing, support and behaviour in comparison with linear models informed by a 'treatment first' philosophy. By doing so, the model aims to overcome barriers to engagement and

prevent ongoing exclusion from services. However, the level of choice afforded to clients is also likely to vary across different implementations of HF.

Choice is justified on humanitarian grounds as enabling clients a greater sense of control over their lives. Choice is also justified on grounds of being an effective mechanism for pursuing subjectively desirable outcomes related to recovery from mental health and substance misuse issues, and desistance from offending and 'street culture' activities (Padgett et al., 2006; Tsemberis et al., 2004).

Both recovery and desistance are understood as inherently personal processes, best informed by a client centred approach. In desistance literature, this process refers to the ongoing absence of an event; offending (Maruna, 2001; Walker, Brown, & Bowen, 2013: 287). In turn, White (2007: 235) defines recovery from substance abuse as:

"the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilise internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive and meaningful life"

Finally, Anthony (1993: 527) describes recovery from mental health problems as:

"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles... a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness".

As the above definitions emphasise, recovery is a personal and voluntary process, favouring a 'client centred approach'. In HF, the chosen mechanism for enabling a client centred approach is consumer type 'choice'. In the first instance, 'choice' is offered over housing, support, and behaviour but these choices more widely inform the trajectories of HF clients (see section 2.7.5).

The HF model has successfully challenged the view that MEH adults cannot maintain independent accommodation, by demonstrating high housing retention rates.

However, there is little evidence to suggest the model, and therefore the mechanism of choice, enables subjectively desirable, recovery and desistance orientated outcomes.

Literature on recovery and desistance emphasises both moving away from harmful behaviours and towards a meaningful and positive life by personal and societal standards (Bonney & Stickley, 2008; Ellison, Belanger, Niles, Evans, & Bauer, 2016; Groshkova & Best, 2011; Kazemian, 2007). Therefore, clients need to negotiate choices that lead them towards, for example; education, employment, and positive social networks as well as away from 'negative' behaviours such as substance misuse and offending.

The limited success of HF in this area is perhaps unsurprising given the 'multiple and complex' needs of many MEH adults, compounded over long periods in situations of poverty, homelessness, and institutionalisation (Fitzpatrick et al., 2011; Fitzpatrick et al., 2012; Fitzpatrick & Bramley, 2015). Subsequently, MEH adults face a number of intersecting recovery and desistance journeys, each of which are understood as being long and fraught with relapse (Cornes et al., 2014). HF clients face a high number of complex intertemporal choices as they make 'steps' on their recovery journey. These choices are so complex because they involve intersecting issues and amending deeply rooted behaviours, compounded over many years (Terry & Cardwell, 2015). In particular, the limited outcomes achieved in relation to substance misuse in HF have demonstrated the challenging nature of these processes (Kertesz & Weiner, 2009).

HF clients must also make choices that enable them to maintain their housing, which provides the foundation for the pursuit of other outcomes. In more paternalistic homeless hostels, utility bills, council tax, furniture, and even food is commonly organised by the provider. In HF, these choices (and the accompanying responsibilities) fall upon the client, with support from the service. Clients are required to negotiate formal processes of setting up accounts and paying bills. They are also required to budget their benefit entitlement to avoid sanctions such as fines, interest payments, or even eviction. For the

majority, these processes are either completely new, or their previous experience has been interrupted by long periods spent in homeless situations.

Overall, HF clients face a wide range of very complex choices, which have consequences that play out over time. They must influence their trajectories away from harmful behaviours and towards a positive and meaningful life by personal and societal standards. This 'project of self' noted in section 2.7.5 by Holland and Thomson (2009) preferences an informed, optimising, rational, and well-resourced actor, both in terms of material, social, and cognitive resources. The next section interrogates the assumptions of rational, optimising actors that underpin the promotion of greater choice by exploring the broad literature on decision-making. In doing so, the assumptions of a rational actor model are quickly dispelled and instead a 'bounded' understanding of rationality is highlighted.

3.3: From Rational, Optimising Actor to Bounded Rationality

Historically, the most influential theories for understanding decision-making have been utility maximising or rational choice theories (Rolfe, 2009). These theories have origins in classical economics and in basic terms assume that human beings are rational actors, gathering all appropriate information and weighing up this information to choose the most appropriate course of action. The most appropriate action alternative is that which maximises utility to the greatest extent, in other words it brings the best possible outcomes to the actor. Kahneman, Wakker, and Sarin (1997) tell us that there are two types of utility of relevance. Firstly, utility in Bentham's sense which reduces the concept to the experience of pain and pleasure. Secondly, and more common in the last century, is the use of utility to describe our desires. Rational actors are expected to know their desires and make decisions to fulfil them.

Rational choice theory has been widely critiqued, particularly in the fields of behavioural economics, psychology and social policy (Barnes & Prior, 1995; Kahneman & Tversky, 2000; Rolfe, 2009; Sen, 1997). These critiques generally centre on the theory's instrumentalist approach and its lack of psychological and sociological realism. Rational

choice theory assumes the availability of sufficient information to provide perfect knowledge on which to act, as well as presuming that this information is of an objective quality, without influence from other social actors. Granovetter challenges this view, arguing that:

“Actors do not behave or decide as atoms outside a social context, nor do they adhere slavishly to a script written for them by the particular intersection of social categories they happen to occupy. Their attempts at purposive action are instead embedded in concrete, ongoing systems of social interactions”

(Granovetter 1985: 487 c. Hedström 2005).

Rational choice theory also assumes that all actors have sufficient cognitive abilities with which to process information, allowing them to choose the course of action that maximises utility and optimises outcomes. In turn, all actors are assumed to consistently possess sufficient motivation with which to gather and process information, and decide upon the optimal course of action.

It is important to note that there is no disagreement that optimising outcomes is desirable; it is simply that humans are generally unable to do so. Further, there are large inequities in individual actor's ability to optimise. Simon (1956) offered a more realistic criteria for choosing a course of action when he noted that we 'satisfice' rather than optimise. In other words, we seek to *satisfy* our need to choose a course of action in a given situation by identifying one that *suffices*. This is because the time, information and cognitive restraints that a decision is contingent on necessitate that we do so. Based around these restraints, Simon proposed a more realistic term of 'bounded rationality'. In turn, he proposed that exploring models of bounded rationality was a way of advancing our knowledge on decision-making and the resulting actions. Famously, Simon noted that; *“rationality is bounded by a scissors whose two blades are ‘the structure of task environments and the computational capacities of the actor’”* (1990:7). In doing so, Simon provides a broad framework for exploring how decision making (and the resulting actions)

vary amongst actors, by exploring the relevant capabilities of the actor to make choices, as well as the influence of the setting in which choices are made.

3.4: Contextualised Rational Action

With reference to housing theory, Somerville and Bengtsson (2002) promoted a more developed conception of rational action: ‘contextualised rational action’ theory, which the authors argue sits between constructivist and realist accounts, within a critical realist ontological perspective. Like Simon, the authors recognise the important role of social context in determining the choices, and resulting actions of individuals. They utilise Elster’s (1983) concept of ‘thin rationality’ where by individual actors are assumed to have some logical consistency in pursuing their goals, but do not always optimise. Of utmost importance are the goals and preferences of individual actors, which must be identified and analysed without assumptions by the researcher. Tracking the pursuit of goals means that time is also an important component in a contextual rational action approach. “*The method can be described as a rationalistic version of historical process tracing (George & McKeown, 1985) where ‘path dependence’ (Putnam, 1993) is of importance and ‘critical junctures’ (Collier & Collier, 1991) and ‘formative moments’ (Rothstein, 1998) are crucial as points of analysis*”. (Somerville & Bengtsson, 2002: 124). Contextualised rational action therefore shares a focus with the pathways approach, more common in homelessness research (Clapham, 2003)⁵. In contrast to traditional rational actor theory in which actors are assumed to act rationally all the time. Somerville and Bengtsson start with the assumption that humans actors rationally *on the whole*.

Somerville and Bengtsson’s (2002) more critical perspective on rationality aligns well with the situational approach taken in this study. A situational conception of rationality is that individuals act according to the situation in which they find themselves, *as they see it* (Popper, 1994). Perception is therefore an essential aspect of understanding why

⁵ The ‘pathways’ approach is discussed further with reference to a situational approach in section 3.6

individuals choose to engage in certain actions. In turn, enquiry must focus primarily on the actor's perceptions of a situation. The importance of perception highlights the interpretive traditions that underpin rationalistic analysis and continue to inform contextual and situational approaches (Bengtsson & Hertting, 2014). As Somerville and Bengtsson (2002) concede, the open-endedness of a 'thin rationality' approach also limits its explanatory value. This open-endedness may speak to a wider reluctance to pay serious attention to the cognitive foundations for individual action in sociological or criminological accounts (Kazemian, 2007).

More recently, a contextualised rational action approach was applied to the field of homelessness by McNaughton Nicholls (2009) in one of very few direct enquiries into the decisions and actions of homeless individuals. McNaughton Nicholls explored transgressive acts that lead to homelessness, arguing that these can be understood as having a 'thin rationality'. Essentially the author argues that the participants at the centre of her case studies were acting rationally given the context in which they were operating. McNaughton Nicholls references Buchanan's work on heroin use in 1980's as an example, highlighting how structural conditions, such as decline of traditional industries, teamed with the availability of a painkiller with euphoric qualities helped many young people gain relief from the social economic realities of their lives. In this situation, the use of heroin could be seen as rational. (Buchanan, 2004; Buchanan & Young, 2000).

Set within a critical realist framework, contextualised rational actor theory certainly provides a useful, albeit loose framework for exploring why individuals engage in certain actions. The strength of a critical realist ontological perspective is that it allows for complex view of causality, asserting that the same factors will not necessarily always lead to the same outcome for all people (Fitzpatrick, 2005). However, recognising complexity does not necessarily mean denying clarity in explanation. Although useful in moving beyond false conceptions of optimising rationality, this study did not find that 'thin rationality' or a contextualised rational action approach offered a sufficiently clear

framework for empirical enquiry into the factors that influence the choice to engage in a certain action.

Section 3.5 presents what I see as a more substantive and clear framework for understanding individual choices and actions; situational action theory (SAT). Although this theory has been applied to explaining *the decision* to commit crime, I argue that the approach can be broadened to provide a useful framework for explaining decisions made during processes of recovery and desistance. With its focus on the interaction between person and setting, SAT is largely complimentary to a contextualised rational action approach, yet proved more useful in providing understanding of the data.

The following section will outline a situational approach to understanding the factors that influence the choices towards recovery and desistance orientated outcomes for MEH adults. The originators of SAT, Wikström and Trieber (2016) argue that situational analysis should form the core of criminological theory. However, at present proper situational theories are rare, so the theory is used here outside it's original subject area. In contrast, SAT offers a robust situational framework. Consequently, the following section outlines the key concepts and propositions of a situational approach, employing the framework offered by SAT.

3.5: Situational Action Theory

Situational Action Theory (SAT) is a recently developed theory that incorporates existing individual and ecological explanations of why individuals choose to commit crimes (Wikström 2004, 2005, 2014). Much like Somerville and Bengtsson (2002), Wikström and Trieber (2016) lament the lack of robust situational analysis with many accounts tending to focus more heavily on either the person or environment. However, as Wikström (2014: 75) describes, both are essential components alongside the role of 'time' (see section 3.6) in understanding why individuals choose to engage in certain behaviours.

"People commit acts of crime because they perceive and choose (habitually or after some deliberation) a particular kind of act of crime as an action alternative in

response to a specific motivation (a temptation or provocation). People are the source of their actions but the causes of their actions are situational. Particular combinations of kinds of people (personal propensities) and kinds of settings (environmental inducements) promote the perception of particular kinds of action alternatives and choices (some of which may result in actions that break the rules of law) in response to particular motivations (temptations or provocations)."

The theory more widely amounts to a complex action theory, sitting within discipline of analytical sociology and the ontological perspective of analytical realism (Hedström, 2005; Hedström & Bearman, 2009). Little (2012) notes that analytical sociology is based on three key ideas. First, that social outcomes should be explained through the actions of individuals. Secondly, that actors are socially situated; their preferences, perceptions, emotions and ways of reasoning are influenced by the social world in which they operate. Thirdly, that social explanations should be based in understandings of the causal connection between one event and another. The proponents of analytical sociology argue that these connections are best understood through mechanisms.

SAT is an example of a mechanism-based theory commonly associated with analytical sociology as it focuses primarily on micro level processes and actions to explain broader social phenomena (Hedström, 2005). As Bengtsson and Hertting (2014) remind us, social mechanisms are difficult to define. Nevertheless, the authors posit that *"mechanisms are regular patterns of specific kinds of actions and interactions, patterns that are causally productive, meaning that they bring about certain outcomes"*. (p.4)

For this study, the social phenomenon in question is the recovery and desistance, or lack of recovery and desistance, among HF clients (Woodhall-Melnik & Dunn, 2015). The study seeks to explore the mechanisms that either facilitate or hinder recovery and desistance. To do so initially requires micro level analysis into participants' situational capacity to utilise choice to achieve recovery and desistance orientated outcomes. A

focus on micro level, fine analysis is a defining quality of mechanisms. Tracking how participants utilise choice to pursue outcomes allows a detailed description of this process.

This study is not solely concerned with criminal acts or moral rule breaking. Nevertheless, as SAT is concerned with individual actions, the theory still provides a substantive framework for understanding decision making more generally. This study is ultimately concerned with an individual's ability to make recovery and desistance orientated choices that enable them to move away from harmful behaviours and towards a meaningful and positive life by personal and societal standards. Although situational approaches are present in desistance literature, there is a general paucity of such approaches in studies of recovery or homelessness. Alongside others, Farrington (2007) called for further enquiry into situational factors as well as cognitive or decision-making processes in the study of desistance. This call seems to have answered, at least in part. For example, Weaver (2015) includes situational accounts alongside other key classifications of explanations of desistance: individual and agentic, social and structural, and interactionist. It is important to note that although some explanation of individual decisions are offered in Appendix B.3, this study's primary concern is with the factors which influence MEH adults capacity to make choices and how these interact to influence recovery and desistance trajectories.

Wikström's contention that *"people are the sources of their actions but the causes of their actions are situational"* both 'takes the actor seriously' and recognises the important role of various environmental factors in framing the objective and perceived possibilities for action. The key strength of the situational framework offered by SAT is in offering a clear framework for explaining how personal and environmental factors come together to influence an individual's capacity for choice. According to an analytical approach, SAT draws into focus those factors of most relevance to the phenomena being

studied (Hedström, 2005; Hedström & Bearman, 2009). Importantly, those factors at the centre of enquiry are not constitutive of all factors, just those of most importance.

It is worth noting the key differences between SAT and the broader situational approach employed in this study. To clarify the discussion that follows, figure 3.1 highlights the overarching framework of the situational approach used in this study.

The key difference between Wikström's situational analysis, which focuses on explaining crime, and my own situational analysis, which seeks to explain choices in the context of trajectories away from MEH situations, is the widening of focus. Firstly, SAT focuses primarily on the moral rules of actor, and how these conflict with moral norms. Wikström and Treiber (2007: 5-6) note that *"the foundation of a general theory of crime is not the law but the existence of moral rules (of which laws are a special case)"*. Wikström defines morality as *"the rules that stipulate what is right or wrong to do or not do in a given situation"* (Gallupe & Baron, 2010: 2).

The analysis employed in this study broadens these terms including legal and social norms alongside moral norms, and referring to the preferences of actors rather than their moral rules. Notions of right and wrong are inherent in recovery and desistance processes. The issues individuals must begin to overcome are often transgressive, encouraging stigma and sanction from wider society. However, as explained further in section 3.5.3, social norms can also explain why these acts are deemed transgressive. In turn, a key theme in recovery and desistance literature is that of moving towards a positive life, defined by the individual but also influenced by wider social norms, rather than moral norms alone.

Secondly, Wikström's concept of executive capabilities, which refers to a set of cognitive faculties used to make decisions is broadened to include not only the ability to recall experiences (stored as internal representations) but also those experiences themselves, as ultimately an actor can only recall what they have experienced. Capabilities are explained further in section 3.6.3. In this section it is worth highlighting

that to engage in activities valued by wider society (e.g. employment, maintaining a tenancy), previous experience of these activities is useful.

Finally, 'needs' are included in the analysis of 'person' and 'opportunities and resources' are added into the analysis of 'setting'. Although neither of these areas are the focus of enquiry in SAT, they are deemed useful areas of analysis when considering recovery and desistance orientated choices in HF.

'Needs' are a consistent point of focus in literature on MEH adults, but there has been very little definition of the term. They commonly refer to the presence of issues in areas such as substance misuse, mental health, offending, and immersion in 'street culture' activities. What is vital is that despite the associated negative consequences, the individual struggles to address these issues alone. As a result, the support of others is commonly required to overcome them, or at least limit their negative consequences (e.g. engaging with treatment). In 'treatment first' philosophy, these may be understood as deficits in an individual's ability to live independently. As HF provides independent housing without any requirements of housing readiness, these issues should be understood as deficits in an individual's ability to pursue a positive and meaningful life more broadly. The extent and complexity of needs vary across the MEH population (Fitzpatrick et al., 2012). Analysing how these 'needs' vary across participants will allow a more detailed understanding of how they impact their ability utilise the mechanism of choice.

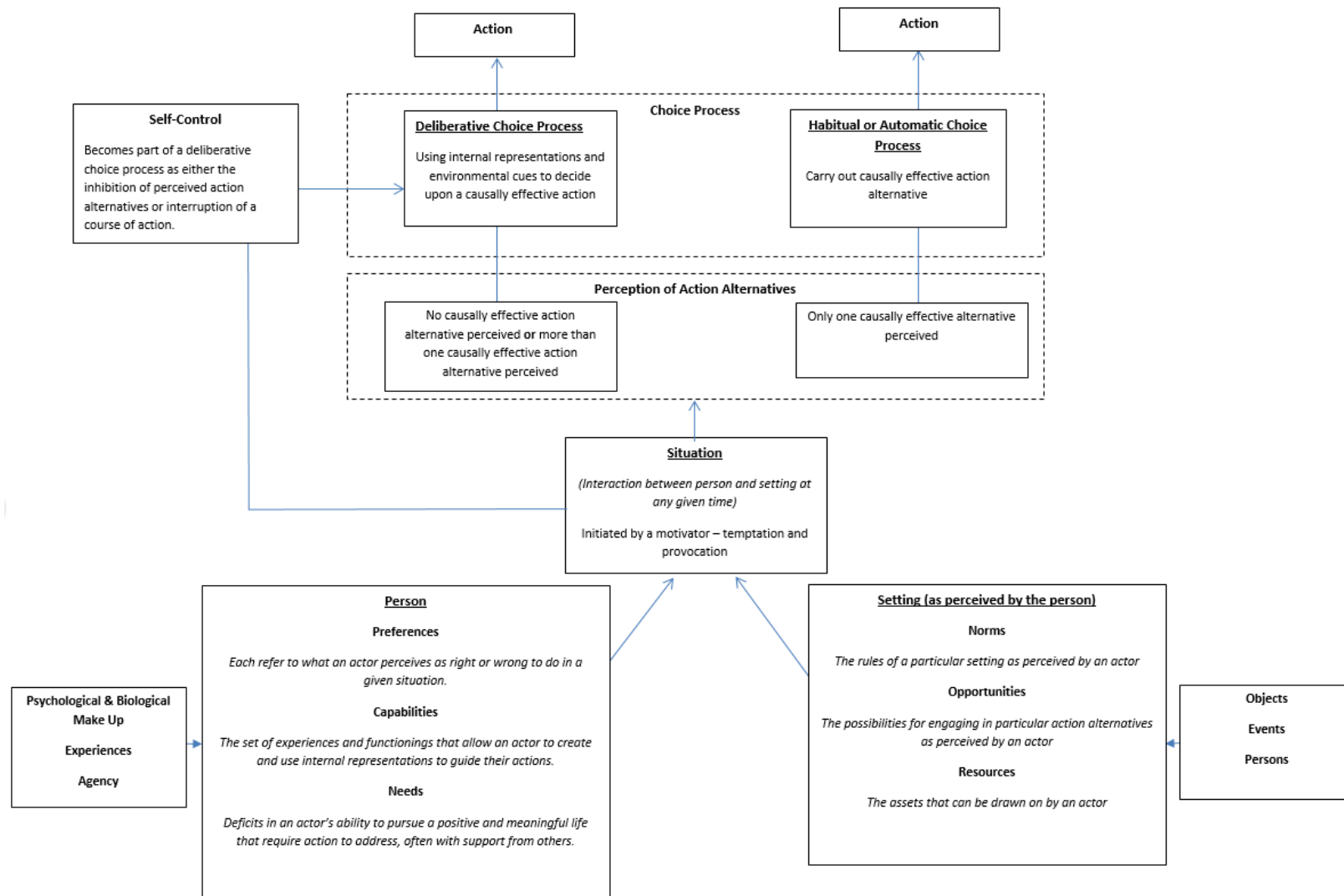
'Opportunities and resources' are included as a means of exploring the structural and institutional factors which shape participants' possibilities for choice. In particular, their ability to access activities and support essential for overcoming needs (e.g. mental health treatment) and developing capabilities which enable wider social inclusion (e.g. education, employment).

Apart from these amendments, the broader situational framework remains the same as that employed in SAT. As highlighted in figure 3.1, the interaction between person and setting emerges at a particular moment in time, creating a situation. This

situation in turn determines the motivators and their effect on the individual as well as the individual's perception of action alternatives. Self-control is understood as a situational concept, relying on personal and environmental factors, and only occurring if an individual engages in a deliberative choice process (Wikström & Treiber, 2007).

The remainder of this chapter is structured by the key concepts of a situational approach; 'person' (3.5.2), 'setting' (3.5.3) and 'time' (3.6), illuminating the influence of each on individual capacity for choice. These sections pay particular attention to the factors likely to influence MEH adult's capacity to utilise the mechanism of choice. Before this, section 3.6.1 discusses the perception-choice process through which these factors intersect to produce actions.

Figure 3.1: Theoretical Framework of a ‘Situational Approach’ to Explaining Decision Making Processes



3.5.1: The Perception – Choice Process

SAT relies on an understanding of two successive filtering processes in decision-making occurring in a particular situation. Wikström (2014) identifies this as the perception-choice process.

The process is initiated by a motivator, which Wikström (2014) categorises as either temptation or provocation. Temptation refers to the intersection between personal desire to engage in an action and setting based opportunity to engage in an action, both of which must be perceived by the actor to constitute a motivation to engage in a perception-choice process. Provocation refers to a motivator that emerges from an actor's setting and evokes negative emotions (usually anger) in the actors that incite a desire for action.

Once a motivator has initiated the process, the first step is to perceive action alternatives deemed causally effective, in the process excluding those that are not. If during the first filtering process, the actor perceives one causally effective action alternative, they will carry out that action, in what is referred to as an automatic choice process. If no causally effective action alternative is perceived *or* more than one causally effective action alternative is perceived, then a deliberative choice process is initiated. Kahneman (2011) categorises these dual processes as 'thinking fast' (where we intuitively perceive the correct action alternative to carry out); and 'thinking slow' (in which we go through a deliberative choice process, searching for an appropriate action alternative or weighing up a number of action alternatives which may be causally effective).

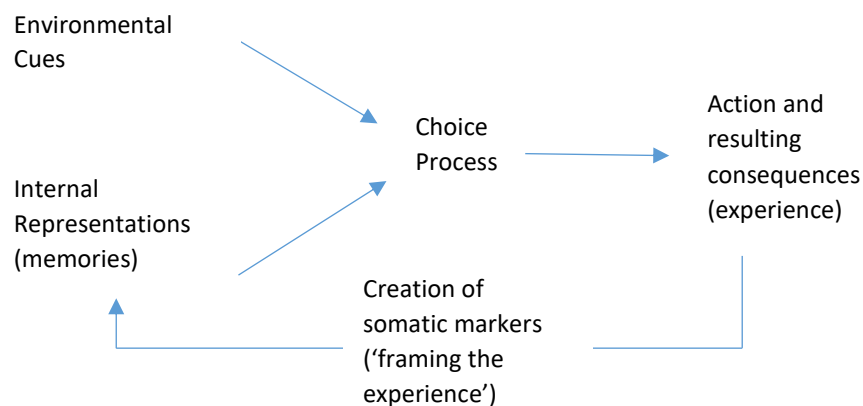
Wikström (2014) also notes that familiar settings favour automatic choice processes that evoke behavioural habits. As we have acted repeatedly in similar ways in this setting, we believe we intuitively understand the resulting consequences. This is of particular interest for MEH adults entering processes of recovery and desistance. Research in desistance (Laub & Sampson 2001; Macdonald & Marsh, 2000; Webster et al., 2006) recovery (Dingle et al., 2015; Groshkova & Best, 2011), homelessness

(Ravenhill 2012), and HF (Nelson et al., 2015) has highlighted the particularly important role that familiar settings can play in hindering progression towards a positive life by societal standards. Section 3.6.3 discusses the role of local social networks further, now we turn to the role of personal factors in a situational approach.

3.5.2: The Multiply Excluded Homeless Actor (Person)

An analytical perspective draws into focus those components deemed of most relevance to the phenomena in question. In the first instance, a person is broadly understood as consisting of a psychological and biological make up, a sum of experiences and the capacity for agency. Psychological and biological make up and our experiences are interrelated through the creation of (and ability to recall) memories. Memories are interpretations of an experience stored as internal representations, rather than perfectly accurate reflections (Wikström, 2004; 2014), As displayed in figure 3.2, internal representations stand alongside environmental cues, as the two broad sets of information are available to an actor when they are making a decision.

Figure 3.2: Relationship between experiences and decisions



Of course, these processes are more 'messy' than this, as Freese notes:

“Explaining particular actions is thereby an indefinite project, in which the narrative network may extend backward in time, inward to the psychology/physiology/neurology of

actors and outward to the social and physical environments in which actions are determined” (Freese, 2008 c. Freese 2009: p.96).

Biographies are therefore an essential source of information when studying individual choices. Wikström (2014) concurs, positing that the way to best understand a person’s narrative network and their make-up is through their personal biography. This approach is widely used in qualitative ‘pathways’ approach and the contextualised rational action approach (Clapham, 2003; McNaughton Nicholls, 2009).

Further, evidence outlined by Kahneman (2011) supports such an approach by conceptualising our subjective lives as being understood as a story or a narrative. Kahneman (2011) notes that the ‘remembering-self’ composes stories of the situations in which somatic and emotional markers are attached to experiences. These are stored for future reference in the form of internal representations (memories). When faced with familiar environmental cues in new situations, which have similar somatic and emotional markers, relevant internal representations are accessed. In this way, we can understand that we are the sum of our experiences, but only in the way in which they are subjectively perceived.

By processing and storing experiences in this way an individual develops particular capabilities, and preferences, representative of norms in their environment but also unique to the individual. When making choices towards recovery and desistance, individual ‘needs’ also play a central role. Exploring individual biographies allows exploration of how these needs developed, in turn enabling exploration of their complexity. Biographies also offer important information about the strength of behavioural preferences and extent of relevant capabilities for utilising the housing and support offered in HF to pursue recovery and desistance.

Wikström (2014) posits that of particular influence on our future choices and actions are our social and moral education, our cognitive nurturing and the incidence and extent of trauma and associated emotional stress. Each of these are important

considerations for MEH adults who have often emerged from disadvantaged backgrounds.

The highly subjective nature of decision-making warrants micro level analysis, as employed in this study. However, it is still useful to illuminate some characteristics and shared experiences of MEH adults to add context to the findings of this study. The remainder of this section turns to overlapping biographical factors that influence MEH actor's capacity for choices towards recovery and desistance, framing them as needs, preferences, and capabilities.

Early Life Experiences and the Development of 'Needs'

The term 'multiple and complex needs' is commonly applied to MEH adults. This term usually focuses on the co-existence of some combination of mental health, substance abuse, homelessness, and offending. Each of these 'needs' is representative of a stigmatised identity, which can lead to wider social exclusion (Buchanan, 2004). 'Needs' do not feature in SAT, but are used in this study to refer to deficits in an individual's ability to pursue a positive and meaningful life, often requiring support to address. Further, each 'need' can hinder an individuals' ability to make deliberative recovery and desistance orientated choices as they encourage higher levels of emotional stress and intoxication in everyday life. Both emotional stress and intoxication restrict an individual's capacity for self-control, and therefore their capacity to make deliberative choices (Wikström & Trieber, 2007).

To explain the influence of each 'need' it is first necessary to explore the origins of these needs. Doing so requires enquiry into the shared childhood experiences of MEH adults. MEH adults often involve growing up in financially vulnerable circumstances (Fitzpatrick et al., 2012). In turn, MEH adults commonly share stressful experiences of trauma and neglect, particularly in earlier life (Fitzpatrick et al., 2012; Fitzpatrick & Bramley, 2015). More broadly, Shonkoff et al. (2012) argue that this 'toxic stress' in childhood leads to impairments in learning, behaviour, and both physical and mental

wellbeing. They argue that many development disorders begin in early life and are associated with experiences of poverty, discrimination and maltreatment.

More recent research has re-affirmed the link between financial vulnerability, parental distress, and poorer outcomes in life for children (Harold, Acquah, Sellers, & Chowdry, 2016; Treanor, 2015). It is not enough for parents to simply be physically present; three environmental conditions essential to optimal human brain development are nutrition, physical security and consistent emotional nurturing (Siegel, 2001). The child needs to be in an attachment relationship with at least one reliably available, protective, psychologically present and reasonably non-stressed adult.

Maté (2010, 2012) explains that adverse experiences in childhood, alongside a lack of loving social connections can cause significant, long lasting consequences. As Maté (2010: 201) puts it *“their experiences and interpretations of their environment, and their response to it, will be less flexible, less adaptive, and less conducive to health and maturity”*. Van der Kolk (2015) highlights the reluctance of psychiatrists to take these traumatic early life experiences seriously. He argues that too often, childhood behavioural issues are treated with medication, which can have further harmful effects on the ability to these individuals to engage in productive and meaningful lives.

The ability to manage emotions has very real consequences for HF clients making choices about housing and welfare. Baxter and Glendinning (2013) explored the role of emotion in choices around welfare and found that these are commonly stressful decisions, evoking feelings of fear, worry, stress, isolation and anger among participants. For individuals who have had traumatic pasts, the challenge of making these choices would be likely to be even more difficult. In fact, it has long been recognised that when certain experiences trigger emotional reactions there can be consequences for behaviour. Emotions such as anger encourage a desire for quick action, hindering the actor's ability to gather all appropriate information and discouraging a deliberative choice process (Elster, 2009; Turner & Stets, 2005).

Adverse childhood experiences and the (in) ability to manage emotional stress can also contribute to substance abuse (Sinha, 2001). Substance abuse is a common issue amongst MEH adults, even after rehousing (Kertesz et al., 2009). Ongoing substance abuse hinders recovery and desistance, and represents a risk factor for homelessness (Fitzpatrick, 2005; Kemp, Neale, & Robertson, 2006; Van Roeyen et al., 2016). The Adverse Childhood Experiences (ACE) study related substance abuse problems to childhood experiences. The study looked at incidence of ten separate categories of painful circumstances including family violence, parental divorce, death of a parent and physical or sexual abuse (Felitti et al., 1998; Foege, 1998). For each 'ACE', the risk for early initiation of substance misuse increased two to four times. They also found that two thirds of intravenous drug use could be attributed to abusive and traumatic childhood events. One reason for this is that opioid, depressant, and stimulant type drugs stimulate release of endorphins and dopamine limited in stressful childhoods, encouraging repeated and compulsive use (Maté, 2012).

Elster (1996) notes that it is plausible to assume that as an emotion induces a desire to engage in an action in conflict with known moral and social norms, it also biases cognition to obscure the wrongness of that action. These impacts can also be compounded further when we consider the close relationship between emotional nurturing and social nurturing. Our understanding and adherence to particular social values can be strongly associated to the moral guidance (or education) received during childhood (Wikström et al., 2012). The value we place on this guidance depends on the strength of our attachment relationship to those offering guidance, most commonly parents. Without appropriate attachment in developmental years, our ability to adhere to wider social values may diminish. In turn, our understanding of how to act in certain situations are 'skewed' away from mainstream social and moral norms.

Of course, parents are not the only influences on an individual's notions of right and wrong, institutions such as schools play a key role. However, MEH adults engaged

poorly with formal education, often experiencing exclusion and have very limited experience of formal employment (Fitzpatrick et al., 2012; Fitzpatrick & Bramley, 2015). As a result, their ability to adhere to wider social and moral norms may be further limited, as they do not engage with more mainstream norms and values encouraged in formal education. Analysis by the Department for Work and Pensions (DWP, 2017) has recently identified that children growing up in workless families are almost twice as likely as children in working families to fail at all stages of their education.

As well as encouraging the development of needs, these childhood experiences are often followed by experiences of exclusion and disadvantage as adults. The combination of these experiences can compound needs, and affect the preferences of MEH adults, as well as their limiting their ability to develop capabilities relevant for the pursuit of a positive and meaningful life.

Transgressive Preferences for Action

In this study, preferences refer to what an individual perceives as right or wrong to do in a given situation. These preferences also represent wider goals in life, which are inherently rooted in personal beliefs about the 'right' way to live. Studies exploring the future goals or priorities of homeless individuals have demonstrated that their preferences often revolve around day to day priorities associated to 'getting by', rather than long term goal planning (Busch-Geertsema, 2002; Helfrich & Chan, 2013). Bowpitt, Dwyer, Sundin and Weinstein (2011) focused specifically on the priorities of MEH adults. They identified that their priorities were not fixed but evolve with changing experiences and circumstances. Like Busch-Geertsema, they noted that very few wish to remain homeless. They also found that participants wished to regain a sense of self-worth, or to reconcile with family as well as overcoming behaviours that had a detrimental impact on health and wellbeing. However, for many, longer term priorities around securing and retaining accommodation are superseded by day to day survival needs, as well as meeting their

drug and alcohol needs. These needs conflict with the priorities of the agencies that support them, maintaining their homeless situation.

Neither substance use, offending, nor 'street culture' represent wider norms about the 'right way to live'. In contrast, each behaviour contravenes mainstream moral, social, and legal norms bringing material and non-material sanction (see section 3.5.3). However, each are consistent experiences amongst MEH adults. Although transgressive, offending, and 'street culture' activities such as begging can be understood as 'thinly rational' means of making money given the circumstances of MEH adults. In the first instance, substance use may also be understood as a 'thinly rational' means of separating from past trauma, and present exclusion. However, substance abuse changes and damages the parts of the brain responsible for decision-making, particularly the orbito-prefrontal cortex and the pre frontal cortex more generally (Maté, 2012). As a result, sustained drug addiction can tune the decision-making processes of individuals away from the deliberative, rational processes assumed by policy makers. Instead, they are tuned towards habitual processes such as when the short-term relief provided by the drug supersedes any perceived long-term benefits or negative consequences resulting from engaging in these transgressive behaviours.

Behavioural preferences can demonstrate similarity to others, which encourages social bonding. They may also provide useful signals with which to police cultural boundaries. Freese (2009) notes that the preferences of 'mature' actors and society more widely are for preferences shaped by socialisation and other civilising processes of contemporary society. Within self-control theories, 'mature' preferences are generally associated with delayed reward. Gintis (2000) situates these more valued behavioural preferences as displaced from the state of nature and instead more in keeping with a capitalist economy. In turn, these preferences are represented in the recent shift to 'active citizenship' in UK welfare policy (Dwyer, 2010).

MEH actors do not commonly present an image of 'mature' actors. In contrast, they commonly engage in offending, 'street culture' activities, and substance abuse. In the process, they demonstrate behavioural preferences that are undesirable and stigmatised (Johnsen, Fitzpatrick, & Watts, 2014). The 'chaotic' behaviour of MEH adults does not represent 'mature' preferences in mainstream society.

As MEH adults behavioural preferences are often deemed undesirable by social and moral norms, we can understand that these may represent additional challenges for reintegration (Quilgars & Pleace, 2016). If the aim of a HF service is to support inclusion in mainstream society then it must encourage adherence to the norms of that social setting, or hope the persons in that social setting will be tolerant of the complex challenges their new neighbour is facing. Positive social contact enhances subjective wellbeing (NEF, 2013) and supports recovery and desistance (Laudet & White, 2008; Mezzina et al., 2006; Topor et al., 2006). However, engaging in such social contact may be challenging when faced with the knowledge that the other individual may strongly disapprove of your behavioural preferences, in either the past, or now (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993; White, 2007; White & Kelly, 2010). As well as amending these behavioural preferences, and overcoming needs, HF clients also need to develop capabilities relevant for pursuing the positive and meaningful life in definitions of recovery.

The Capabilities of MEH Actors

Sen's capabilities approach (1993, 1997, 1999) is employed as a broader conceptualisation of capabilities that that used in SAT, which focuses primarily on the ability to process and recall memories. Sen's approach is concerned with an individual's capability to live a good life. This is defined in terms of a set of 'functionings' such as having positive, supportive relationships with others or having a skill that is useful to others. Therefore, Sen's approach is primarily concerned with a person's capability to do valuable acts or reach valuable states of being (as defined by their setting).

Using Nussbaum's essential functions (capabilities), McNaughton Nicholls (2010) employed a similar approach to explore the role of housing in enabling homeless individuals to live a 'well lived life'. Unlike Nussbaum, Sen has been reluctant to endorse any list of what it is people should be capable of, instead seeing our capability as dependent on their setting.

The recognition in this approach of the complex interaction between person and setting fits well with an analytical realist ontology and a situational framework. In turn, Sen understands functionings and capability as developing through the same broad process as described in section 3.5.2. However, in order to aid clarity in discussion between a situational framework and a capabilities approach, I will refer to Sen's concept of 'functionings' as 'capabilities' in my own analysis.

One of Sen's key arguments is that people differ in their abilities to convert similar resources into a set of valuable capabilities. This notion is particularly useful for the study of HF in Newcastle, whereby clients are offered similar resources in terms of housing and support (see 2.8.2). These resources provide the foundation from which clients pursue recovery and desistance orientated outcomes. The question of whether these similar resources bring similar outcomes is of primary concern for this study.

Therefore, the capabilities approach has particular usefulness for measuring equality across participants by asking the question 'equality of what?'. The approach goes beyond intangible measures of 'success' (such as how much choice participants feel like they have) to focus on what people are capable of. Subjective measures are rife across HF evaluations and constitute the majority of outcomes recorded beyond housing retention (see section 2.6.2). Measuring perceived levels of mastery and quality of life is important. However, the capabilities of participants are likely to differ according to their experiences, in turn, affecting their ability to utilise the resources and opportunities provided by HF to pursue recovery and desistance. The incorporation of personal capabilities also enables an individualised approach in line with recovery and desistance

literature (see section 3.2). In turn, within a situational framework, analysis of personal capabilities can demonstrate areas in which particular participants may require further support to achieve longer-term outcomes.

This study is concerned with the pursuit of recovery and desistance related outcomes in PRS housing in a HF service. Therefore, it is important to establish a set of capabilities that are broadly relevant to the capacity to achieve a 'well lived life' in this situation, both in terms of personal priorities and wider social norms. Concentrating solely on personal priorities ignores the influence of capabilities on subjective desires. As Sen notes (1993) our capability not only determines what we can be, but who we think we can be. He argues that deprivation can lead individuals to lower expectations and take greater pleasure from small achievements but these successes will not make the deprivation go away.

Identification of capabilities must also focus those which fit with wider social norms, as these ultimately determine the extent to which clients can become socially and economically included. These capabilities are likely to include, amongst others, experience of tenancy sustainment, education and employment. In general terms, MEH adults and those facing 'severe and multiple disadvantage' more broadly, have limited experience of education, employment, and housing (Fitzpatrick et al. 2012; Fitzpatrick & Bramley, 2015). However, Fitzpatrick & Bramley (2015) also identified that although limited, experiences in each of these areas varies across the population.

Identifying difference in participants' experience of relevant capabilities and comparing this to their ability to utilise the resources, opportunities and 'choice' offered by HF is an essential consideration for this study. In HF implementations, we may consider that the expectations of clients will vary along with their experience of deprivation and other influencing factors. For example, an individual who has had a job, owned a home and had a close family before experiencing homelessness may have very different expectations of what they can (and should) achieve in life than an individual who has been

in care since an early age before entering a homeless situation, therefore experiencing primarily institutional forms of support.

Within a situational and a capabilities approach, the interaction between person and setting is key. To this point, discussion has focused heavily on the person. The next section shifts attention to the setting, exploring the role of local social networks, opportunities, and norms in influencing MEH adults' capacity for choice.

3.5.3: Environments of Exclusion and Disadvantage (Setting)

In SAT, a setting is broadly composed of persons, objects and events, the combination of which produces moral norms which guide conduct in that setting. In line with an analytical and critical realist understanding, a setting is composed of various layers. 'Macro level' structural layers intersect with 'meso level' institutional layers and 'micro level' local social networks.

This section discusses the common factors in MEH adult's environments, both in the past and after entering HF, across each of these layers. These factors overlap and are analysed in terms of norms, opportunities and resources. As highlighted in section 3.6, this study employs a broader conceptualisation of norms. Also of relevance are the extent to which an actor's setting allows opportunities for action and determines access to resources that support the pursuit of recovery and desistance.

In recovery and desistance literature, the social context is of particular importance in either enabling or hindering these processes (Patterson et al., 2013; Walker et al., 2013). With a positive orientation, personal and professional networks can offer essential emotional and practical support, alternative means of coping and enable feelings of belonging (Topor et al., 2006). However, they can also hinder or even halt any progress if they are negatively orientated towards peers who encourage harmful behaviours (Dingle et al., 2015). Engaging in education or gaining employment can help create a more positive sense of identity essential to catalysing and maintaining recovery and desistance processes. However, the effects of stigmatisation often manifest in discrimination from

activities and networks essential for greater social inclusion (Buchanan, 2004; Quilgars & Pleace, 2016). In turn, social inclusion is deemed as essential to overcoming each of the needs discussed in this chapter. The next section examines the prominent role of local social networks in influencing choice.

Local Social Networks

Of particular importance in a situational examination of choice are those people whom an individual has the greatest degree of interaction, their local social networks. Local social networks have a major impact on the norms perceived by the actor, and determine the type of motivators that initiate choice processes (see section 3.5.1). Local networks are important because people respond most to the actions of those closest to them. Rolfe (2009) defines closeness in terms of “*cohesiveness, physical location, similarity and frequency of contact*” (p.434). The prominent influence of these local networks is of particular relevance when considering the homeless setting, in which homeless individuals with varying social and personal issues live in congregate settings. We can quite easily understand that living in a congregate setting means that homeless individuals are physically located closer to other homeless individuals, and therefore they have a greater frequency of contact. If we consider that groups of homeless individuals have gone through similar experiences in life as well as having and experiencing the same stigmatised identity then we may also understand that similarity exists (Prince & Prince, 2002).

Common experience of substance misuse or street culture activities may also compound these similarities and lead to closer social bonds, as individuals engage in these behavioural preferences together. Studies employing social identity theory demonstrate that being part of the stigmatised ‘homeless’ identity encourages the formation of social relations with those who share that stigmatised identity (Hogg, 2006; McCarthy, 2013).

The sense of closeness and influence of local social networks is likely to be compounded over time for MEH adults, who face longer-term homelessness. This may go some way to explaining the presence of a 'homeless culture' in which separate sets of norms are developed which conflict with those of wider society (Ravenhill, 2012). As individuals with similar behavioural tendencies (such as substance misuse or offending behaviours) generate closer social bonds and greater influence over each other, they compound these behaviours.

The close links developed during time spent homeless can hinder recovery and desistance processes. For instance, Dingle, Stark et al. (2015) offer recent evidence to suggest that 'substance using' social groups can hinder recovery and separating from these associations may be an important factor in enabling recovery. Yet, separating from these associations may make it more likely that they will experience other issues such as loneliness and boredom (Johnsen, 2014), ultimately leaving individuals with a choice of 'bad company or no company'.

Ongoing support from social networks can also support recovery (Best et al, 2010; Topor et al., 2006). England Kennedy and Horton (2011) found that family can offer resource provision and forms of intangible support such as providing transportation, or simply 'being there' and offering encouragement. However, relationships with family can also cause barriers to recovery. Trust issues and miscommunications caused tensions in relationships, which limited familial support and increased emotional stress for those in recovery.

What is essential is that social networks must be orientated in such a way that they offer positive, enabling support which limit stress and separate individuals from substances. The high incidence of adverse childhood experiences in the biographies of MEH adults suggest that positive romantic or familial relationships may be limited. Identifying and accessing positive, enabling support may be a significant challenge in achieving recovery and desistance orientated outcomes. This places greater importance

on the quality and extent of support provided through HF. The case management model employed in Newcastle (see section 2.8.2) means that a great deal relies on gaining access to professional support and wider opportunities for developing capabilities (e.g. education and training).

Opportunities and Resources

Opportunities for action (the action alternatives that people perceive as available to them) affect how people make choices because they feed into behavioural preferences. In line with Sens capabilities approach, Petersen (2009) suggests that people commonly adapt their preferences to the opportunities they have. The interdependency of choice relates opportunities for choice to social constraints such as strategic reasoning and cognitive comparison, as people align their choices according to perceived social norms. However, they also apply in a more objective sense, for instance the structural availability of employment opportunities and the extent to which these match individual capabilities.

Providing equal opportunities for desired action is an often-cited mechanism for challenging economic and social inequality. The concept of ‘opportunities’ has also been central to social policy and welfare provision since New Labour. Rather than the redistribution of wealth, the redistribution of opportunities became the shaping notion of policy. However, a more critical reading of the concept of opportunities in UK welfare policy shows that they are increasingly linked to paid employment, particularly since the processes of welfare reform accelerated in 2010 (Dwyer, 2004; Dwyer & Wright, 2014). This is particularly true for those who are unemployed who must adhere to a rising number of conditions upon their receipt of welfare, largely related to them moving back into paid employment. As such, opportunities for those who are unemployed have a narrow definition with little actual choice afforded to the individual. Further, Dame Carol Black’s (2016) recent review highlighted the significant barriers to employment posed by drug and alcohol addictions, another experience common across MEH adults, and often related to early life experiences (see section 3.5.2). Black suggests a ‘fresh approach’ is

needed which brings together health, social, and employment agencies together in ways personalised to the individual.

This recognition of the multiplicity and individuality of substance use needs further demonstrates the need for individual level analysis, as highlighted in reference to MEH adults 'capabilities' at the end of section 3.5.2. As with equality in capabilities, equality in opportunities only forms part of what is required for actual equality in economic, social and cultural terms. Dworkin (1981) identifies that equal material and social resources are required to perceive and actualise outcomes. In modern liberal societies, the inequality of resources at birth leads to the inequality of outcomes due to different material resources and capabilities for utilising more equal opportunities. Many MEH adults grow up in situations of disadvantage in which their parents are unemployed. Studies have shown that this significantly increases the probability that they will also face unemployment in adulthood (Gregg, Jerrim, Macmillan, & Shure, 2017; Schoon et al., 2012). Essentially, their opportunities to pursue social and economic inclusion on these terms are limited at birth.

Poverty is a manifestation of economic and social inequality in a society. In turn, experience of poverty has been consistently demonstrated as a risk factor for homelessness and MEH more specifically (Johnsen & Watts, 2014). Poverty restricts the material resources available to individuals, inhibiting their ability to access appropriate opportunities and perceive or act according to their priorities. Over the life course, processes of social exclusion compound this process further (Pleace, 1998).

Social exclusion theory emerged alongside an understanding of poverty as multidimensional and as part of a cumulative process of social exclusion (Gordon et al. 2000; Sen, 2000). Theories of social exclusion illuminate the compounding impact of poverty over the life course in restricting the opportunities available for the pursuit of a positive and meaningful life. Individuals are not entirely powerless and can play some part in slowing or accelerating their own social exclusion, but ultimately they have very little

opportunity for real choice about their lives (Ravenhill, 2012). As a result, the capabilities of 'socially excluded' individuals are unlikely to be valued by wider society, hindering their ability to pursue a positive and meaningful life.

The structural distribution of opportunities and the cumulative impact of these over the life course highlights important considerations for the trajectories of participants in this study. These individuals have commonly experienced extreme forms of poverty and social exclusion over the life course (Fitzpatrick et al., 2012). Moving from homeless hostel to HF tenancy is a good start, but more is required to move away from these experiences. Clarke et al. (2008) highlight that the structural distribution of opportunities and resources represents a key issue for the use of 'choice' as a means of guiding this journey. The authors posit that the use of consumer type 'choice' in public service provision ignores the service delivery context, in which the available options and resources are limited.

Ultimately, single interventions such as the Newcastle HF service cannot support recovery and desistance alone. Broader socio economic factors such as low income, unemployment or poor housing all emerge as barriers to achieving the self-fulfilment central to recent conceptualisations of recovery (Bradshaw et al., 2007). *'The five year plan for Mental Health'* published by the Mental Health Taskforce to the NHS (2016) acknowledges the disproportionate experience of mental health issues amongst those who are living in poverty, are unemployed and are facing discrimination. Overcoming these adverse circumstances necessitates the involvement of wider gatekeepers to social inclusion.

Employers, treatment providers, and landlords all have essential roles in guarding access to social networks and activities vital to pursuing a positive and meaningful life. For social inclusion, accepting and enabling social environments are also essential (Tew et al., 2011; Topor et al., 2006). This poses questions for a community based service in which wider processes in the social mainstream may act to exclude and discriminate against those they aim to support.

One particular concern highlighted at the end of section 3.5.2 is the ability to access support essential for overcoming needs and developing capabilities. A wide range of barriers have been highlighted around effective multi-disciplinary working (Cameron, 2016; Cameron, Lart, Bostock, & Coomber, 2014). This is particularly true for individuals with 'multiple and complex' needs, with the familiar issue of 'dual diagnosis' preventing access to essential treatment (Drake et al., 2004; Laudet et al., 2000; Priester et al., 2016). However, recent evaluations have demonstrated that the strategic partnership approach to 'multi-agency' working around homelessness in Newcastle is particularly effective (Harding et al., 2013). Whether this strategic approach is able to accommodate individuals who are repeatedly excluded from accommodation and support services is less clear (Cornes et al., 2011) (also see section 2.8.2).

Norms and Exclusion

As well as largely defining the opportunities that are available to 'choose' from, social setting also defines the norms of behaviour and conduct. Bengtsson and Hertting (2014) position norms as a key factor determining individual action. This section will briefly explore how these norms contribute to processes of social exclusion by sanctioning and isolating norm violators, influencing their choices further. First, it is useful to differentiate between key types of norms.

A key distinction to make is between social norms and moral norms. Elster (2009) tells us that social norms are distinguished from moral norms in terms of the emotions that sustain them and the causal structures that link emotions to norm violations. Moral norms are internalised beliefs about conduct, whereas social norms are externalised and dependent upon others observing and expressing contempt (Elster, 1991; Elster, 2009).

The concept of social norms is widely used in social sciences as a categorisation for implied ways of acting in given social situations. However, the broadness of the term is paralleled by a lack of general agreement on definition. In relation to social capital, key

social norms can be defined as shared civic values, and habits of cooperation (Van Oorschot & Finsveen, 2009; Young, 2014).

In this way, we may understand norms in a neoliberal sense as being an instrumentally rational means of preventing market failure and of maximising welfare through cooperation and reciprocation. This norm provides context to Clarke et al's (2008) conflict between client choice and public service delivery. They highlight the conflict between the concept of public provision and of individual choice. As the taxpayer ultimately funds welfare provision, they should have some recourse to ensure that this money is not being spent ineffectively and solely to meet the wants and desires of those in receipt of welfare payments. Positive change is expected through contribution to society, generally understood in terms of gaining employment (Dwyer & Wright, 2014). The long, challenging process of recovery and desistance suggests that for many, this repayment may not be forthcoming.

In this way, social norms that favour paid employment can be understood as at least unrealistic, if not unachievable for some (Etherington & Daguerre, 2015). This example is one representative of Elster's (2009) conceptualisation of norms as sources of suffering. This suffering can be categorised by the impact of sanctions for norm breaking behaviours as well as the fear of these sanctions. Sanctions come in various forms according to the norm type and behaviour. Arguably, violation of legal norms first brings a material sanction, which in turn results in a non-material sanction related to the stigmatised identity of a criminal. Whereas violation of a social norm first brings a non-material sanction, for instance in the expression of contempt.

MEH adults are categorised by their experience of homelessness as well as engagement in behaviours such as offending, substance misuse, and 'street culture activities' such as begging (Fitzpatrick et al., 2011). Each of these behaviours conflict with social and legal norms. As such, this group are also categorised by repeated exclusion from various forms of accommodation, treatment and support. Exclusions are commonly

on grounds of behaviours that conflict with norms defined by legislation, continuum of care models, and the necessities of health and safety in congregate housing situations (Ridgway & Zippel, 1990). As a result, these individuals become trapped in cycles where they fail to conform to the norms that many others live by and so spend more time with other MEH adults, making it more difficult to adopt 'mainstream' norms.

The counter effect of the sanctions MEH adults face are feelings of shame and social rejection. As Frijda notes *"social rejection constitutes severe punishment, and most likely not merely because of its more remote adverse consequences"* (1986:351). The emotional impact of perceived social rejection and shame is likely to compound these behaviours, particularly around substance misuse. Based on research with over 200 problem drug users, Buchanan (2004) highlighted the debilitating nature of marginalisation and social exclusion faced by these individuals, restricting their ability to achieve social inclusion.

A key aim of HF is to aid social inclusion and moving individuals back into the community is therefore a necessary step. However, norms which preference reserved and civilised behaviours are also present in tenancy agreements, housing benefit sanctions, ASBO's, and parenting orders through the 'Trouble Families' program (HoC, 2017). As a result, a high number of behavioural conditions are still present even after leaving homelessness. HF clients need to negotiate these norms to avoid sanctions such as imprisonment or eviction, which may hinder or even halt their recovery and/or desistance process. As noted in previous sections, moving to housing in the community may not necessarily amend the norms that surround the client, particularly when housing is provided through a market based PRS model (see section 2.8.1). Due to structural barriers related to housing affordability, many clients may find themselves in lower socioeconomic areas in which social norms are largely representative of those in which clients' needs emerged (McNaughton Nicholls & Atherton, 2011). Expecting sustainable change in behaviours is optimistic and supports the notion that 'choice' simply passes

responsibility to the client, with little real possibility of long term change (Löfstrand and Juhila 2012)(also see section 2.7.5).

This section has summarised the role of setting in influencing MEH adults, capacity to make recovery and desistance orientated choices in HF. The final section explores time as a theoretical construct through which the influence of personal and setting based factors intersect.

3.6: The Importance of Time

Time is an essential component in a situational approach, playing a number of roles in influencing decision-making processes and the resulting actions. As decision making processes occur in situations, the point in time at which the decision is taken defines what the exact setting will be as well as the 'person state' of the actor as they enter a decision making process. The length of time taken to make a decision can also reflect the type of decision taken. For instance, negative emotion provokes a tendency for immediate action, related to an intolerance for inaction when emotionally compromised (see section 3.5.2). Further, familiar settings tend to provoke automatic choice processes.

However, the most expansive influence of time on decision-making comes in when we consider the accumulation of experiences, decisions and resulting consequences over the life course. In turn, these have shaped the psychological and biological make ups of people, leading them to adopt particular needs, preferences, and capabilities.

The relationship between a clients' future goals to their ongoing choices is of central importance, as explained further through the concept of intertemporal choice (Berns et al., 2007). As noted in section 3.2, intertemporal choices are decisions with consequences that spread out over time. It is not within the remit of this chapter to go into the broad psychological and economic literature on intertemporal choice. However, we may understand that the ability of clients to reach service outcomes of reducing substance misuse, ceasing offending and 'street culture' behaviours and developing mental wellbeing are all largely dependent on their situational ability to make good intertemporal

choices. Essentially, this is by identifying action alternatives that result in actions with negative long term consequences and express self-control to suppress these action alternatives. Subsequently, clients must also identify and promote action alternatives with positive long-term consequences. In the process, clients must also forego the desire for immediate action or relief that can emerge from emotional stress and substance misuse.

The intertemporal nature of the choices clients face is recognised in the original Pathways implementation of HF and many others. In this model, choice is 'repeatedly and assertively offered' (Tsemberis, 2010) within a context of open-ended support. This method of encouraging positive choices by offering them repeatedly can be related to '*critical junctures*' (Collier & Collier, 1991), '*formative moments*' (Rothstein, 1998) (Somerville & Bengtsson, 2002: 124) and Giddens' (1991) 'fateful moment' concept. Each of these concepts refer to the point at which individuals reflect and make a choice that has a significant impact on their lives. Offering choice repeatedly and doing so in the context of open-ended support increases the service's ability to influence that 'fateful moment' of reflection to bring about a positive impact.

Giddens' concept fits within a wider understanding of time as a theoretical lens. To understand how MEH adults translate their capabilities and opportunities to recovery and desistance orientated actions it is vital to try to explore the turning points, transitions and trajectories, as well as the various historical, present and future agential and structural influences on this (Holland & Thomson, 2009; Laub & Sampson, 1993; Thomson, Bell, Henderson, McGrellis, & Sharpe, 2002).

The 'pathways' approach to homelessness research (Anderson, 2003; Clapham, 2003) provides a framework for such an enquiry and fits well with a situational approach in which the 'person', as an accumulation of experiences, is best understood through their subjective biography. The pathways approach also provides a means of exploring the role of time in enabling sustainable change in the lives of MEH adults. As Clapham (2003)

outlines that the pathways approach focuses on the interaction between structural and agentic factors to provide a holistic analysis.

The process focuses on tracking the interaction between these two sets of factors through time, within individual 'pathways'. This approach does not offer the same analytical focus on the relationship between choice and action, but does consolidate the temporal aspect of the situational approach well. The approach is also useful in tracking the non-linear nature of recovery and desistance pathways, common throughout accounts of recovery from homelessness, substance addiction, mental health, and in offending desistance literature (Cornes et al., 2014; Neale et al., 2014; Padgett et al., 2016; White, 2007). Particularly useful is the idea of mapping the interaction between personal and environmental factors within individual participants' pathways through HF, covered in more detail in section 4.4.2.

As highlighted throughout this chapter and Chapter 2, clients face significant challenges in amending deeply rooted needs and developing relevant capabilities that enable a meaningful and positive life. This research is ultimately limited by the practical constraints of a 3-year PhD study, meaning that observing such change is unlikely. However, it is likely that 'trajectories' towards recovery and desistance can be established within the 15 month period of data collection. The use of 'trajectories' to measure progression in other HF studies further supports this approach (Johnsen, 2014; Patterson et al., 2013) (section 2.6.3).

3.7: Conclusion

This chapter has outlined a theoretical framework for enquiry into the factors that can affect the capacity of MEH adults to utilise the mechanism of choice to bring about subjectively desirable outcomes. To do so, sections explored key developments in theory explaining decision-making processes that underpin actor's choices.

First, section 3.2 identified the type of choices faced by clients after entering their HF tenancy. It is posited that clients must make intertemporal choices that are recovery

and desistance orientated, referring to both a transition away from needs and developing capabilities for a more positive life. Such choices preference a rational, optimising actor such as the type assumed in rational choice theory.

However, the notion of a rational, optimising actor has been successfully challenged in psychological and sociological literature. Instead, a 'bounded' understanding of rationality will be adopted in this study (Simon, 1990:7). Theoretical understanding of rationality and decision-making has advanced further since Simon but has generally followed an understanding of rationality as 'bounded' by personal and environmental factors. Contextualised rational action is cited as an example of such a theory (Somerville & Bengtsson, 2002). The theory essentially highlights the contextual nature of actor's choices. Operating under a critical realist ontology, Somerville and Bengtsson understand context as complex and multi-layered but broadly related to the individual and their setting. They also posit an understanding of rationality as 'thin', with actors making decisions broadly in line with their goals, but not all the time. Although very useful as a starting point, 'thin' rationality and contextual rational action only offered a broad framework, making detailed enquiry into individual decision-making processes difficult.

Instead, a situational approach, informed by Wikström's SAT was posited as a more substantive theoretical framework. A situational understanding posits that choices can be understood as resulting from extremely complex decision making processes which are informed by an individual's personal capacities and make up, as well as the setting in which the choice is made. Time can be understood as being the medium through which the influence of 'person' and 'setting' act to influence choice.

A situational understanding is broadly complementary to contextual rational action, with each employing realist ontologies. SAT utilises an analytical realist perspective that promotes micro level analysis as a necessary first step for explaining broader social phenomena. This level of detail is particularly useful in exploring the inherently personal decision-making processes with which this study is concerned. In

addition, both contextual rational action and situational action theory place analytical focus on 'person', 'setting', and 'time' to explain the factors that influence individual choices. Therefore, these three areas of enquiry formed the structure of the remainder of the chapter.

With reference to MEH adults in HF, three areas are of particular relevance when exploring their capacity to make recovery and desistance orientated choices: 'needs', 'preferences', and 'capabilities'. 'Needs' refer to the broad set of 'multiple and complex' issues MEH adults face: substance misuse, offending, mental health, homelessness, and 'street culture'. A range of literature has related these issues to adverse early life experiences, often in the context of poverty. In particular, experiences of trauma and neglect can negatively affect cognitive capacity. These early life experiences negatively affect a person's ability to regulate emotions, and make it more likely that these individuals will experience mental health and substance misuse issues in later life. For MEH adults, these issues often persist over many years, meaning that these behaviours become preferences and habits. As these behavioural preferences commonly conflict with wider social preferences for acceptable behaviour, demonstrated in wider social, moral, and legal norms, MEH adults are exposed to further opportunities for harm, trauma and exclusion. As a result, recovery and desistance literature highlights the considerable challenge of overcoming mental health, substance abuse, and offending respectively. This challenge is amplified by the limited capabilities MEH adults often possess for pursuing a positive life by societal standards. This poses a significant problem for a study seeking to define and measure 'success' for these individuals. Sen's capabilities approach is highlighted as a useful framework for doing so. A capabilities approach is primarily concerned with what a person *can do or be* as the basis for measuring progress. The recognition of the complex interaction between person and setting fits well with an analytical realist ontology and a situational approach.

The setting in which decision-making processes occur provides the environmental cues for action, and defines the norms and opportunities which govern behaviour. Of primary importance in determining norms and providing motivators for action are an actor's local social networks. These networks are also noted as important protective or risk factors in recovery and desistance literature, depending on their orientation. For MEH adults, these networks are likely to consist of individuals with very similar needs, encouraging behaviours that are in conflict with wider norms (e.g. substance misuse and 'street culture' activities). HF goes some way to separating these individuals from these networks by offering independent, scattered site housing. However, HF clients face the reality of leaving homelessness to move back into poverty. In turn, they can face significant structural barriers to accessing opportunities for wider social and economic inclusion.

In section 3.6, time is explained as a theoretical lens, allowing enquiry into the interaction between person and setting. Time is relevant in terms of the type of choice process engaged in, as well as the accumulation of experiences over the life course, as reflected in particular needs, preferences, and capabilities. In order to interrogate the capacity of MEH adults to utilise 'choice' in HF effectively, the methodology employed in this study must enable an examination of the person (HF client), setting (including local, institutional, and wider structural factors) and time (both in terms of tracking participant trajectories in HF, and situating these in their 'whole lives').

4: Methodology

4.1: Introduction

This chapter outlines the research design and methodological approach used in this study, including discussion of the particular methods of data collection and analysis that were employed.

Section 4.2 begins the chapter by offering an overview of the research design. This design is rooted in the literature and theory outlined in Chapter 2 and 3 through a brief summary of the key points emerging from each review (section 4.2.1). These summaries lead to consideration of key ontological and epistemological perspectives that inform the methodological approach of this study (4.2.2).

In section 4.2.3, a Qualitative Longitudinal Approach is selected as the best approach for understanding 'success' for each individual participant in HF, as well as understanding how their capacity for choice and control manifests and changes.

In section 4.2.4, a mixed methods approach selected as best means of measuring success for a group whose outcomes are so broad. Personal priorities included and given weighting as a means of personalising outcome measurement in line with individualised and unique process of recovery.

Section 4.3 covers the purposive sampling strategy employed in this study, as well as providing some reflection on how this strategy was adapted as a result of challenges faced in recruiting participants to the study.

The Qualitative Longitudinal approach used in this study offered significant flexibility to adapt the research design to unexpected circumstances, but also to personalise data collection to each participant. To explain this inductive approach, section 4.4, '*Data Collection and Analysis*' is structured according to the chronology of the study. This structure was selected as the best means of allowing the reader to better understand

when and *why* methodological challenges and innovations occurred over the course of the study. These innovations are largely representative of ethnographic approaches.

Formative analysis undertaken between waves of data collection is discussed throughout section 4.4. Section 4.5 then focuses on the final process of analysis, occurring after data collection had concluded. This process focused on finalising individual level analysis before comparing across the experiences of participants, allowing critical interrogation of the relationship between ‘choice’, ‘control’ and ‘success’ in HF and recovery pathways more broadly.

In section 4.6, the chapter concludes with consideration of the key ethical issues that emerged throughout the process of data collection and analysis.

4.2: Research Design

4.2.1: Research Aims and Literature Review

This study primarily sought to explore notions of choice and control within a HF model and how these contribute to the achievement of successful outcomes for MEH adults in Newcastle upon Tyne.

Two key definitional questions emerged from these primary research objectives; what do ‘choice’ and ‘success’ mean for these individuals? In order to anchor the approach and methods used to evaluate each of these concepts in the contemporary knowledge base, two literature reviews were undertaken.

Temporality, and subjectivity were recognised in the literature focusing on definitional questions of what entails ‘success’ for this group (see sections 2.6.2, 2.6.3 and 3.5.2). Non-linear pathways were a dominant theme in accounts of recovery from homelessness, substance addiction, mental health, and in offending desistance literature (Cornes et al., 2014; Neale et al. 2014; Padgett et al., 2016; White 2007). These pathways are evidently fraught with relapse and set back, further emphasising the need to measure

change over time, in order to gain a more representative and accurate portrayal of participants' progress.

In Chapter 3, it emerged that individual rationality, agency, and therefore choice, were influenced by a complex interaction of personal factors (mainly informed by biological and psychological make-up and experience) and environmental factors. In line with this theoretical understanding, it is essential to understand the biography of an individual, and those personal factors that influence their choices. With reference to their environment, it is essential to understand both their subjective perception of this environment, as well as more objective factors such as the opportunities and resources they can utilise. Finally, it was evident that many of the choices that participants will make are intertemporal, with consequences playing out over time. In order to fully evaluate and understand how participants' choices affected their ability to realise successful outcomes the research design must represent and capture this temporality.

Each review pointed towards particular ontological, epistemological and methodological approaches, as well as demonstrating that each of these concepts can manifest in highly individualised ways.

4.2.2: Ontological and Epistemological Considerations

Interpretivist and Phenomenological Traditions

Those sociological traditions most concerned with the subjective experience and its relation to wider social norms are interpretivism and phenomenology. Max Weber is the academic most associated to interpretivism. His work centred on the interpretive understanding of social action in order to arrive at a causal explanation. Causality was central to the critiques of positivism from which Weber's work emerged. Weber (1949) insists that one should never accept aggregate correlations as explanatory until they have been broken down into intelligible patterns of individual action.

Weber contention is central to an analytical realist perspective, from which the key theoretical framework for this study originates (see section 3.5). The importance of perception highlights the interpretive traditions that underpin rationalistic analysis more generally, and continue to inform contextual and situational approaches (Bengtsson & Hertting, 2014). A situational conception of rationality is that individuals act according to the situation in which they find themselves, *as they see it* (Popper, 1994). Therefore, the interpretivist tradition underpins the approach taken in this study through its inherent focus on the subjective experience and understanding of human action (Bryman, 2015). As the nature of rationality, decision making and successful outcomes are so individualised for those facing multiple and complex needs, any study which seeks to explore notions of choice, control and success must engage with these traditions.

Nevertheless, there does still seem to be an objective world which can influence decision making and capacity for 'success', without being subjectively understood by the individual. As such, interpretivism alone is insufficient as an epistemological framework.

Realism

Realist positions have become increasingly influential in contemporary accounts of human action after being disparaged by positivists and interpretivists alike. Philosophic realism in general is defined by Phillips (1987: 205) as "the view that entities exist independently of being perceived, or independently of our theories about them".

In broad terms, this study is more aligned with critical and analytical, rather than empirical realism (Bryman, 2015). However, it must also be recognised that critical and analytical realism draw together a wide range of epistemological approaches. Being realist in this sense is not to ignore the importance of subjective understanding of the world. In fact, most forms of realism refute the idea that objective knowledge of the world is possible. Instead, alternative accounts can be valid, and are grounded in particular perspectives, all of which are partial. As such, the subjective accounts of the rationale behind particular actions are essential components of a research design exploring notions

of choice. However, utilising choice to enable greater control also relies upon wider structures, which regardless of how an individual may perceive them, may still act to facilitate or hinder an individual's capacity for control.

In line with the principles of qualitative investigation in general, this study investigates the subjective meaning of success for the actor and their subjective understanding of their choices. However, the study also utilises a theoretical framework (situational approach) to incorporate those factors deemed of most relevance in the literature, but possibly outside of the subjective understanding of the participant. Therefore, outcomes are also identified and measured through an analytic and interpretative process. Yet, this process is also informed by contemporary knowledge of evidence for similar groups (Thomson et al., 2002; Thomson et al., 2006).

As such, even while recognising realist perspective, there is still a need for interpretivist element when exploring the choices of individuals and their relation to 'success'. Frazer and Lacey (1994) support this flexible perspective, arguing that it is possible to be a realist on an ontological level whilst also being an epistemological interpretivist. Additionally, in qualitative longitudinal research often involves a flexible approach to theory, challenging and exposing the static and isolated nature of theoretical frameworks (Thomson & Holland, 2003). Some have even gone as far as noting that qualitative longitudinal research represents a theoretical orientation as much as a methodology (Neale & Flowerdew, 2003). The next section turns to the qualitative longitudinal approach used in this study.

4.2.3: Qualitative Longitudinal Approach

Qualitative longitudinal studies are widely used, drawing on different theoretical; and so methodological perspectives in their design and implementation (Holland & Thomson, 2007). Essentially, they are studies that primarily employ qualitative methods of data collection and analysis and are "*predicated upon the investigation and interpretation of change over time and process in social contexts*" (Holland et al., 2006:1).

With an implicit focus on qualitative principles of meaning and context, the approach provides a useful overall framework for exploring choice and success. The approach is neither deductive, nor inductive, but possesses elements of both, as is often the case, even in studies positioning themselves as strictly inductive or deductive (Bryman, 2015). In the first instance, research questions were based on a series of literature reviews, framing the focus of the research and lending deductive elements to it. However, data collection took place over three waves and 16 months. The flexible approach inherent in a qualitative longitudinal design means that concepts and theory emerged from the data. Bryman (2012) describes this as an inductive approach to theorisation and conceptualisation.

Longitudinal designs are common in social policy evaluations, particularly for interventions which have outcomes and effects which play out over time (Pleace & Wallace, 2011). In turn, inherent in any intervention seeking to amend ingrained behaviours is the notion of change, which necessitates evaluation over time.

The ultimate strength of a longitudinal design and of qualitative longitudinal research in particular is its capacity to explore change over time, in turn, facilitating insight into the interaction between policy and practice (Holland et al., 2006). As this study is primarily concerned with the effectiveness of an intervention which aims to enable change in needs developed over long periods, a longitudinal design was almost essential.

Like most qualitative studies, this study was practically constrained by temporal limitations (Crang, 2003). Therefore, data collection took place over 16 months, primarily set within three waves of data collection at 0 – 3 months, 6 – 9 months and 13 – 16 months. The use of waves in a longitudinal design enabled flexibility to develop and innovate across the research process (Saldaña, 2003; 2011). This manifested both in terms of methodological innovations and establishment of key trends emerging from the data, both of which are outlined in section 4.4.1.

4.2.4: Mixed Method with Qualitative Bias

In research focusing on marginalised and excluded groups, a disconnect often emerges between quantitatively biased, comparative evaluations that primarily focus on ‘*what works?*’ and primarily qualitative research that focus on ‘*how they work and for who?*’ drawing on the lived experiences of those in receipt of interventions and allowing understanding of the predictors of successful implementation (Maruna, 2015; Teddlie & Tashakkori, 2003)⁶.

The most influential evaluations of HF implementations follow a wider trend in ‘evidence based policy’⁷ by privileging the former approach; particularly randomised control trials (Tsemberis & Eisenberg, 2001). However, evaluative research on recovery and desistance has increasingly sought to incorporate both quantitative and qualitative approaches, including the largest scale evaluation of HF to date in Canada (Aubry et al., 2015). Nevertheless, this study represents wider trends that bias quantitative methods informed by positivist approaches. However, as Maruna (2015: 314) notes with reference to offender desistance: “*(mostly qualitative and theoretical) desistance research and (mostly quantitative and applied) program evaluation research are not just compatible but also strongly complementary*”.

As the recovery processes of MEH adults involve a highly individualised combination of needs and capabilities, compounded to varying extents over the life course, there is a clear need to explore the complexity of individual experience through qualitative approaches. This is particularly true when the research focuses on concepts of choice and success, so informed by individual preferences, capabilities and needs. Sen’s capabilities approach (see section 3.5.2) highlights the importance of exploring these differential abilities to pursue outcomes, as a means of measuring equality.

⁶ Also see discussion throughout section 2.6 for relevant studies within ‘Housing First’ Literature

⁷ See Padgett (2017: 10) for a discussion of the preference for quantitative approaches in determining evidence based practice.

Nevertheless, in order to establish the relationship between personal trajectory (and how it is informed by personal choice) and achievement of subjectively and objectively successful outcomes, it is necessary to empirically measure those outcomes using a systematic approach. The broad range of possible outcomes for this group means that a purely qualitative or quantitative design is likely to prove insufficient. As such, this study follows a trend already present in qualitative longitudinal research and evaluative research around co-existing needs by having a qualitative design but incorporating some methods usually associated with quantitative designs (Holland et al., 2006; Pleace & Wallace, 2011). Palinkas (2011; 2015) argues that mixed method designs are deemed preferable in implementation research as they allow a better understanding than either quantitative or qualitative approaches alone.

In this study, I seek to actualise ideas implicit in realist and interpretivist approaches, combining them to both evaluate success on an aggregate basis, while also unpicking the subjective, lived experiences which have contributed to individual trajectories; in short to ask '*whether it works, how it works and for who?*'.

Outcome Measurement

Three main sources were used to formulate the outcomes for participants in this study. Firstly, reviews of evaluations for similar client groups (e.g. Evans, Wells, & Moch, 2003; Pleace & Wallace, 2011; Tabol et al. 2010). Secondly, other HF evaluations (e.g. Aubry et al., 2015; Johnsen, 2014; Nelson et al., 2007; Tsemberis et al., 2004 ; Waegemakers Schiff & Rook, 2012; Woodhall-Melnik & Dunn, 2015). Thirdly, literature outlining the issues and needs faced by those facing MEH (Cornes et al., 2014; Fitzpatrick et al., 2011, Fitzpatrick et al., 2012). A range of domains emerged in which outcomes could be achieved, primarily associated to overcoming the personal issues, but also some more general measures around health, and wellbeing. As the study is concerned with exploring the subjectivities and individualised notions of success, as well as exploring individual's choices in recovery and desistance, most domains were explored using

primarily qualitative questioning. However, the literature did point towards a number of psychometric scales that could supplement qualitative questioning in broad concepts. In doing so, they offered a point of triangulation to improve the internal validity of the study (Onwuegbuzie & Johnson, 2006). In addition, some ‘Gateway’ data⁸ provided by the service provider was also used to measure objective outcomes. Quantitative scales and qualitative questions were drawn together as composite measures within broader outcome domains. The outcome domains are outlined in table 4.1.

Table 4.1: Outcome domains and Sub Domains measured in this Study

<u>Domain</u>	<u>Sub Domain</u>	<u>Data Type</u>	<u>Source</u>
Housing	Allocation	Mixed	Interviews, Gateway
	Retention	Mixed	Interviews, Gateway
	Ontological Security	Qualitative	Interviews, Observations
Mental Health	Support and Treatment	Qualitative	Interviews, Updates
	Subjective Report	Qualitative	Interviews, Updates
Physical Health	Subjective Report	Mixed	Interviews, Single item measure
Wellbeing	Subjective Report	Quantitative	Psychometric Scales, Interviews
Substance Misuse	Support and Treatment	Qualitative	Interviews, Updates
	Subjective Report	Qualitative	Interviews, Updates
Offending	Charges and Convictions	Qualitative	Interviews, Updates
	Conditions (probation)	Qualitative	Interviews, Updates

⁸ ‘Gateway’ Data is data stored about participants on Newcastle City Council’s supported housing database.

Table 4.1 continued

'Street Culture'	Begging	Qualitative	Interviews, Updates
	Street Drinking	Qualitative	Interviews, Updates
	Rough Sleeping	Qualitative	Interviews, Updates
Meaningful Activities	Employment and Volunteering	Qualitative	Interviews, Updates
	Education and Training	Qualitative	Interviews, Updates
Social Connections	Friend and Associates	Qualitative	Interviews, Updates
	Family	Qualitative	Interviews, Updates
	Professional Support	Qualitative	Interviews, Updates
	General Social Trust	Quantitative	Single Item Measure
Finance and Debt	Rent & Bills	Qualitative	Interviews, Updates
	Debt	Qualitative	Interviews, Updates
	Welfare	Qualitative	Interviews, Updates

Psychometric Scales

As a supplement to qualitative questioning, reliable and valid measures of effectiveness were employed which reflected the particular client group and are comparable with other evaluations of housing support services (Pleace & Wallace, 2011).

Reviews focusing on the evaluation of support services (O'Campo, Schaefer-McDaniel, Firestone, Scott, & McShane, 2009; Pleace & Wallace 2011), effectively measuring wellbeing (Clapham, 2010; Dolan et al., 2011; NEF, 2013), and evaluating HF services (Busch-Geertsema, 2013; Johnsen, 2014; Nelson et al., 2007; Pleace, 2016;

Tsemberis et al., 2004) were used to identify a number of appropriate measures, which supplemented the predominately qualitative design. As the study is primarily concern with the subjective meanings of participants in relation to choice, control and success, these measures were incorporated sparingly and shorter versions of measures were used where possible. Incorporating too many of these measures would have dominated the topic guides used in data collection and caused significant disruption to the semi structured nature of the interview. It was felt that too many measures would have restricted the capacity of participants to discuss at greater length areas of more relevance to their decision making processes and their subjective notions of success. In addition, a key element of the research was to compare between these quantitative results and qualitative data on wellbeing, social trust and mastery. In contrast, to quantitative studies which seek to identify overall trends and correlations, this study only sought comparison on an individual level, establishing change and supplementing qualitative data. The particular measures used, and the studies which provide comment on their reliability and validity are listed in table 4.2.

Table 4.2: Psychometric measures used in this study and domains to which they contribute

<u>Domain</u>	<u>Measure</u>	<u>Studies demonstrating reliability and validity</u>
Wellbeing	Short Warwick Edinburgh Mental Wellbeing Scale	(Tennant et al., 2007)
	Satisfaction with Life Scale	(Diener et al. 1985; Pavot & Diener, 2008)
Social Trust	Social Trust Scale	(NEF; 2013)
Mastery	Pearlin and Schooler Mastery Scale	(Eklund, Erlandsson, & Hagell, 2012; Greenwood et al., 2005; Marshall & Lang, 1990; Pearlin & Schooler, 1978; Tsemberis et al., 2004)

Measures were used in some of these areas as they provided a means of quantitative reference for broad concepts (such as wellbeing) which would also be picked up across other domains in qualitative questioning. The scales also enable broad discussion of participants' emotional progress, rather than focusing exclusively on particular domains of their lives. The mastery scale was deliberately chosen as it was utilised in a key study to relate choice in HF with successful outcomes (Greenwood et al. 2005). However, although widely used, there are still questions about the reliability of the mastery scale (Eklund et al., 2012). As this study is primarily concerned with the extent to which choice in HF services actually enable control for the client, this measure was included so its results could be compared with qualitative findings in these areas.

The fallibilities of quantitative scales – performative responses of mastery

The Pearlin and Schooler Mastery Scale (Pearlin & Schooler, 1978) is widely used, yet there are very few studies of its psychometric properties. The American scale has shown good construct and predictive validity and good internal consistency according to classical test theory criteria (Marshall & Lang, 1990). Eklund et al., analysed the psychometric properties of the Swedish scale using more robust Rasch modelling and found that three items (1,3,5) in the scale displayed differential item functioning (DIF), meaning they may be measuring different abilities for different sub groups. In the case of Eklund et al.'s study, DIF manifested between healthy and mentally ill sub groups.

In this study, the usefulness of the Pearlin and Schooler Mastery Scale was variable. For those participants who completed the scale during every wave of the interview (n=9), the change in scores between waves proved a generally useful predictor of participants' trajectories. However, the cumulative scores (scores from all waves added together) showed very little correlation with participants' trajectories or their qualitative accounts of control. In addition, the highest single scores (at an individual administration) were often those of participants with negative or static trajectories. One participant expressed the highest possible score on the scale while on remand for a crime they felt

was an injustice. Of course, there is the chance they still felt high levels of mastery while in this position, but it cannot be ignored that objectively that had very little control over their own life.

This contrasts somewhat to the findings of Greenwood et al., (2005) who found that the choice offered to clients was mediated through mastery to enable successful outcomes. As such, these contrasting trends seemed to require further investigation into the particular questions posed to participants. Eklund et al. (2012) concluded that certain response categories should be reworded due to the issues with particular items in the scale. The qualitative evidence in this study highlights similar issues, with similar items on the scale. The scale invites respondents to either; strongly agree, agree, disagree, or strongly disagree with a number of statements. Two of these statements are reverse coded to encourage more reliable responses. The statements used are as follows:

1. There is really no way I can solve some of the problems I have
2. Sometimes I feel that I'm pushed about in life
3. I have little control over the things that happen to me
4. I can do just about anything I really set my mind to (reverse coded)
5. I often feel helpless in dealing with the problems of my life
6. What happens to me in the future mostly depends on me (reverse coded)
7. There is little I can do to change many of the important things in my life.

A number of these statements seemed to be flawed in their usefulness for this group due to their direct and imposing nature. In contrast to qualitative questioning which drew participants perspectives on choice and control by asking about specific domains, these statements directly ask participants about their sense of control in concise statements. This seemed to draw performative responses from participants which were underpinned by notions of masculinity, potentially resulting from long experiences in a homeless setting and culture, as well as prison environments for some. As Turner and

Stets (2005: 316) note in reference to measuring emotions on scales; *“what people say and what they feel are often at odds and particularly so when defence mechanisms are activated”*. In being directly posed with a statement which overtly challenges their control, participants seemed to respond in defensive and performative manners, resulting in an unrepresentative mastery score:

“Interviewer: I have little control over the things that happen to me.”

“Oh disagree. I’m totally in control”

“Interviewer: Sometimes I feel I am pushed about in life. Do you strongly agree, agree, disagree, or strongly disagree?”

“Oh hey, I’m an ex paratrooper. I don’t think I will be pushed around”

In qualitative questioning, each of these participants noted a range of ways in which they were not in control, with the latter discussing how they were recently financially exploited by neighbours. As such, their qualitative accounts contrasting strongly with being directly asked about their level of control.

As other studies have shown (Ravenhill, 2012) homeless culture operates under often contradictory moral and social norms in which deception and aggression are common. We may infer that after prolonged exposure to this and other similar settings those individuals develop a masculinised ‘front stage’ persona (Goffman, 1978) in which they must demonstrate strength and control to others to avoid exploitation and persecution.

Living within such settings for prolonged periods also exposes participants to being supported by state apparatus and charity, which may also have a contributory role in encouraging many participants to challenge any statement which proposes that they do not have control. The views of many were summarised well in the following quote:

“Interviewer: I often feel helpless in dealing the problems of my life?”

“Nar, I’m not helpless”

In support for homeless adults there has been an increased focus on coaching methodologies which emphasise empowerment. This may also contribute to the risk of performative responses. The quote below represents the response of many when asked about change in their life:

“And, there is little I can do to change many of the important things in my life.”

“It’s up to me to change me life, wey aye. Nee body else can pull me head out me arse bar me.”

Overall, there seemed to be a number of areas in which directly asking participants about their sense of control brought performative responses which contrasted to participants own description of their lives. These performative responses may go some way to explaining Eklund et al.’s (2012) findings. Of course this also poses questions for other, more qualitative elements of the methodology, such as participants’ responding in a performative manner when being asked about personal priority outcomes, another question common in person centred coaching methodologies. These limitations are discussed further in the ‘personal priority outcomes’ section of this Chapter.

Measuring Choice and Control

The study was first concerned with the extent to which choice was enabled for participants. Secondly, whether the level of choice afforded to participants enabled greater control over their lives and recovery trajectories. Thirdly, how control related to subjective and objective measurements of success for participants in HF.

Choice was measured in relation to three key domains common in HF literature; housing, support and behaviour (Gilmer et al., 2013; Greenwood, Stefancic, Tsemberis, & Busch-Geertsema, 2013). Choice over housing was questioned in a range of sub domains including; location, quality and ontological security. Choice over support focused on participants’ access to and influence over the frequency and type of support, as well as the professional providing the support. Choice over behaviour was questioned by

exploring the relationship between needs, capabilities, and preferences which governed participants' behaviour and the moral, legal and social norms in the environments which they inhabited.

Importantly, choice was not simply seen as something which can be offered in a uniform manner. In line with a situational understanding of choice, personal factors as well as the context in which participants were choosing were both considered in order to establish the extent to which choice was enabled for different individuals.

The primary means of measuring control in this study focused on the capacity of participants' to utilise the opportunity provided by the service to achieve outcomes which were subjectively desirable. Previous studies of 'choice and control' in HF have not sought to include the priorities of homeless adults, instead focusing on broad outcomes, but relatively narrow definitions of choice and control informed by psychometric scales. However, by only relying on scales that ask specific questions about the level of choice and control there is arguably an increased risk of performative responses. By incorporating the personal priority outcomes in the design of the project, it was possible to give priority to those outcomes in overall outcome measurement. This proves extremely useful in establishing whether participants had been able to gain choice and control, and steer their housing, support and behaviour towards subjectively desirable outcomes.

By establishing the personal priority outcomes of participants for the short and long term it was possible to explore the extent to which the service enabled participants' to utilise choice in order to subjectively desirable outcomes. In doing so, the barriers and facilitators of choice and control could also be established during analysis.

Personal Priority Outcomes

Investigating the relationship between choice, control and success depends on defining each of these concepts. As outlined in section 4.2.1 each of these concepts are highly individualised. Consequently, in order to capture the capacity of participants to utilise the HF service to gain greater control over their lives and recovery, it was important

to ask participants what they wanted out of their lives and recovery. There is a general paucity of studies exploring the priorities of MEH adults (Bowpitt et al., 2011).

For homeless individuals more generally, the number of research studies remains small. However, they seem to highlight a desire for mainstream housing and lifestyle (Busch-Geertsema, 2002; Helfrich & Chan, 2013). In addition, Pleace (2012) states that evaluations of HF services should incorporate the personal priorities of clients, yet none to date have explicitly done so. The omission of clients' personal priorities from evaluation measures is surprising considering the 'person centred' nature of HF. Other literature on enhancing levels of wellbeing for individuals with mental health problems has also stressed the importance of choice and autonomy (Bacon, Brophy, Mguni, Mulgan, & Shandro, 2010). The underlying aim of greater consumer choice is to enable greater self-determination and increases in levels of wellbeing which are associated (Greener, Powell, & Simmons, 2009). However, if clients' personal priorities are not incorporated into outcome measures their ability to guide their support towards these priorities may be compromised, along with their true level of self-determination. Equally, the ability of commissioners, service providers and researchers to evaluate the extent of success in such services is surely limited if they only use generalised outcomes.

A key methodological reason why the priorities of MEH adults have not featured prominently in evaluations may be due to the seemingly 'chaotic' and irrational behaviour of these individuals, which does not often indicate any long term planning (Bowpitt et al., 2014). However, goal setting is a common feature in supporting homeless adults, even for those with high and complex needs. As such, these individuals are often asked to explore their personal priorities for the future. However, critiques of 'treatment first' approaches which still dominate in the provision for MEH adults, highlight that goals are often centred on changing the perceived behavioural deficits of an individual. In turn, homeless adults are required to demonstrate 'a desire to change' in order to gain access to accommodation and support services (Ridgway & Zippel, 1990).

A key risk for this study was that when asked what their priorities were going forward, participants would reply in a familiar, but potentially performative manner. In turn, they may note generalised outcomes focused on overcoming their issues which do not represent their true priorities, and do not inform their choices over housing, support and behaviour. Soothill et al. (2013) point out the risk of *social desirability bias* affecting the accuracy of self-report data. In short, the social desirability bias refers to the preference to offer information which may be seen favourably by others, while suppressing desires which may not. In the case of this study, social desirability may manifest in participants presenting a 'recovered' self.

The risk of social desirability bias cannot be escaped in a study which places the voices of participants at its centre. However, the flexibility of a qualitative, longitudinal research design enabled the impact to be mitigated to some extent. Firstly, as well as asking participants' directly about their goals for the future, I was also able to draw meaning from other sections of the interview, utilising my interpretive role as a researcher to find evidence of other priorities, as well as evidence to reaffirm stated priorities. Secondly, by building relationships with participants over three waves of interviews (as well as informal contact in between) I was able to return to reaffirm my place as a researcher, rather than any form of gatekeeper. Having numerous contacts with participants also allowed me to discuss participants' priorities directly with them, to explore any change in their perspectives.

Furthermore, it is important to recognise that within an ontological understanding of humans as social beings, it is not possible to escape the idea that our preferences for the future are defined by wider social norms (Granovetter, 1987; Hedström, 2005). In this way, showing preference to priorities which are deemed acceptable by others is not simply an external performance but also represents what the individual feels will enable them a greater sense of social inclusion. As a sense of social inclusion has been strongly

associated to greater wellbeing and utility, performative responses related to social desirability may hinder our understanding of subjective 'success' less than first thought.

4.3: Sampling and Recruitment

Upon initial conception, this study sought to follow good practice in longitudinal evaluation by centring the sampling criteria on participants entering the service on or around the beginning of data collection (Saldaña, 2003). The idea was to establish a baseline that could be used to compare the experiences of clients at similar stages in their HF tenancy. However, as the service recruits clients on an ongoing basis it quickly became clear that this would not enable a sufficient number of participants to ensure internally valid investigation of the study aims. As such, an alternative sampling strategy was conceived which focused on promoting external validity.

4.3.1: Sampling Strategy

The study faced a number of competing challenges in ensuring external validity. It was concerned with evaluating a service designed for a particular local context, yet the service was informed by a model with international credentials; and it targeted a specific client group with similar but also highly individualised needs.

As such, a purposive strategy was sought, which identified a criteria representative of the target group for the service intervention but also for the HF model more generally. As Harding (2013) notes, in a purposive sampling strategy the researcher chooses the participants who best fit the purpose of the research. Patton (2002) elaborates further, noting the purposeful sampling is used in qualitative research to identify and select information rich cases for the most effective use of limited resources. Therefore, a purpose strategy fitted well with a PhD study which involved only a single researcher and sought to gather and analyse rich data related to participants lived experiences in an implementation of HF. As Palinkas (2015) notes, there are no clear guidelines for

conducting purposive sampling in mixed methods implementation studies, particularly when studies have more than one objective.

In this study, a dualism emerged as there are two interrelated criteria for inclusion in HF. Firstly, there are the range of needs usually categorised as 'multiple and complex'. Secondly, there is the manifestation of these needs in behaviours which lead these individuals to stagnate, or become excluded from homeless accommodation projects, and services more generally (Harding et al., 2011). The service in Newcastle, and the HF model in general are concerned with both, but it is the latter that necessitates a different approach to housing and supporting these individuals. As a result, the referral criteria in Newcastle were heavily focused on the actual exclusion of these individuals, leaving them with no other accommodation options reasonably available to them. Therefore, it was reasonable to assume that those entering the service were regularly excluded from accommodation.

The Multiple Exclusion Homelessness (MEH) research project (Cornes et al., 2011; Fitzpatrick et al. 2011) provided a framework which recognised the manifestation of 'multiple and complex needs' in exclusion throughout the life course. As such, the definition of MEH adults used by these academics (broadly including experience of rough sleeping, mental health, substance misuse, 'street culture' activities, and institutionalisation) formed the basis of the sampling criteria. However, there were also practical constraints related to the available data with which to categorise clients into the MEH criteria. Through already developed links with key stakeholders in Newcastle City Council (NCC), who commissioned the service, I was able to negotiate 'read only' access to their supported housing database, which included needs assessments of clients prior as part of referrals into accommodation projects. As, by their excluded nature, most clients had been through a range of homeless accommodation projects, the majority of those listed in the HF service had recent assessments (within the last year) on which to assess adherence to the MEH criteria. Needs assessments are most commonly carried out by

support workers, and are completed alongside the client themselves. There is of course potential for performative responses which over or underplay needs to increase the likelihood of successful referral. Nevertheless, the data available represented the best available means of ensuring a representative sample.

The categories used in these needs assessments, although representative of the MEH criteria, did not marry up perfectly, meaning some amendments had to be made. For example, there was no direct reference to 'street culture' activities for clients, but there was to offending, which is representative of the closely related categorisation of 'multiple and complex' needs. As such, offending was included in the absence of street culture activities. The criteria included recent or current experience of rough sleeping, presence of mental health issues, presence of a drug problem, presence of an alcohol problem, experience of institutionalisation (care, mental health or prison) and history of offending. Each criteria was given a score of 1, with additional weighting (1.5) given to rough sleeping to give priority to those with the most exclusionary experiences of homelessness.

Some potential reliability issues related to the Gateway data have already been outlined. However, there were other issues related to missing data or needs assessments which were completed a number of years earlier. The decision was taken not to exclude clients from the criteria even if needs assessments may be out of date or if one criterion was missing. Instead, missing criterion were highlighted and the sampling hierarchy was taken to the service managers for review. As the hierarchy was reviewed alongside the service managers, some gaps in the criteria could be filled, and errors addressed.

4.3.2: Participant Recruitment

Approaching Potential Participants

Like most research working with homeless adults, access was enabled through service level gatekeepers. In this case, these gatekeepers were the front line case managers who supported clients in HF tenancy. These case managers approached

clients in the first instance, as well as at the following two waves of the research. As such, a primary concern at the beginning of the research was to ensure that case managers had sufficient information about the study with which to approach clients. Case managers had heavy workloads that generally involved travelling to see clients at various times. Another primary concern of this research was that it was beneficial to both clients and front line workers in the service. I did not wish to begin the process of data collection by hindering the working practices of the case managers. Becoming a burden to participants is highlighted as an issue in qualitative research (Saldaña, 2003) and qualitative social work research more specifically (Padgett, 2017). Rather than organising a meeting which would disturb their schedules I approached each individual case manager during 'quiet' periods and explained the research. I had already gained a list of the support workers for each individual client who had ranked highly in my sampling criteria. As I approached each individual case manager I was therefore able to fulfil a dual purpose of explaining the research and asking them to approach a particular client.

As with most studies working with participants with histories of homelessness, a number of barriers emerged in recruiting clients to the study (DeVerteuil, 2004). Firstly, some case managers initially expressed that their client was 'not ready' to be interviewed. At this point further enquiry was required in order to establish the case managers reasoning for excluding a client. Some noted that clients were going through particularly challenging periods in which their mental health was extremely poor and they were regularly intoxicated. Of course, these are issues inherent in the group I was seeking to research, but it would have been unethical and unproductive to aim to interview clients while experiencing these crisis periods (Padgett, 2017). Furthermore it would have risked alienated and undermining the key gatekeepers in the study, the case managers. In these cases it was agreed that I would approach the support worker again at a later date to gather whether the situation had changed. In a smaller number of cases, case managers noted that clients were still settling into their flat. In these cases, a slightly more forthright

approach was taken, by gently reminding case managers that a purpose of the research was to explore how clients were settling in. Negotiating access therefore became a challenge in this research, as it does for many researchers gaining access to participants through professional gatekeepers (Seidman, 2013).

The next barrier was that some clients did not wish to participate in the research. Clients noted various reasons but primarily these were associated to a lack of interest or a distrust of institutional figures, of which a university researcher is one. DeVerteuil (2004) highlights this issue, stating that many research settings for homelessness research are environments of social control, rife with division and internal distrust. I was able to overcome this distrust by asking case managers to remind clients that I was a student, which seemed to situate me as less associated to fears of institutions, or in a small number of cases meeting the client myself while they came into the centre. DeVerteuil notes that in a similar way, his status as 'stranger', independent of those services enabled him to gather more information from participants.

Of course, waiting to clients to be interviewed and approaching others took time, as case managers would forget, or I would not be able to catch up with them directly for days at a time. Therefore, although the first wave of interviews was extended over 2 months, a number of participants could not be included.

A more opportunistic approach

Towards the end of the first stage, the sample method became more opportunistic, also described as convenience sampling (Patton, 2002). This is not to say that it became detached from the purposive sampling criteria. In fact, the scores for many clients were relatively similar and so waiting for one over another became less of a concern. All those who agreed to take part met at least three criteria. However, the barriers faced in recruitment did mean the sample did not solely contain those who were the 'most' multiply excluded (met the full criteria). It is important to reiterate here that the assessments completed on Gateway were imperfect. They were not entirely up to date and many had

missing elements to them. In addition, the hindsight offered by completing ‘life history’ interviews with participants illuminated that issues which were not present in needs assessments (and therefore the sampling criteria) were experienced by participants. For example, one participant who was initially thought to have no mental health issues or history of rough sleeping was found to have significant experience of both. As a result, even though the hierarchy was followed less strictly, it was evident that many participants’ needs were still highly representative of MEH adults.

There was no overt target for recruitment, other than gaining a sufficient number to enable inevitable drop out at later stages, and to ensure internal validity in relation to the study objectives. The first wave, and therefore recruitment ended with 18 participants.

Table 4.3: Basic Demographic Information for all Study Participants

Participants	Demographics				
		Age	Gender	Ethnicity	Nationality
	Arnie	60	Male	White	British
	Bev	45	Female	White	British
	Carl	36	Male	White	British
	Deira	37	Female	White	British
	Gary	26	Male	White	British
	James	30	Male	White	British
	Jimmy	58	Male	White	British
	Joel	45	Male	White	British
	Joseph	60	Male	White	British
	Johnny	44	Male	White	British
	Ian	52	Male	White	British
	Liam	58	Male	White	British
	Lenny	52	Male	White	British
	Lisa	32	Female	White	British
	Lyla	35	Female	White	British
	Linda	26	Female	White	British
Roger	30	Male	White	British	
Sam	28	Male	White	British	

4.4: Data Collection and Analysis

Data collection took place in three waves over 16 months between June 2015 and September 2016. The following section outlines the data collection and subsequent analysis, which took place at each wave, as well as how this informed an inductive form of

research design, with data collection methods informed by the experiences and findings of previous stages.

78 interviews were undertaken in total, alongside around 200 hours of ethnographic observations in the form of case manager updates and informal discussions with client participants.

Table 4.4 : Number of Interviews by Wave and Type

Wave 1 Interview	Wave 2 Interview	Wave 3 Interview	Personal History Interview	Stakeholder Interview (Wave 1)	Stakeholder Interview (Wave 3)
18	15	12	14	10	9

4.4.1: Wave 1

The first wave focused on building relationships with participants and case managers, as well as informing the definition of the outcomes in the project, and the key personal, and environmental factors which may contribute to participants' capacity for choice and control.

Semi Structured Interviews

The first interview explored three key areas. Firstly, participants were asked about their personal priorities for the year ahead in order to individualise their recovery trajectory. Questions also focused on participants' relationship with key stakeholders in their recovery; including their landlord, income provider and support provider, as well as the incidence of behaviours common amongst MEH adults. Participants were also encouraged to discuss at length any decision-making processes that resulted in an action that facilitated or hindered their progression towards subjectively desired outcomes.

Semi structured interviews were selected as the most appropriate method of exploring these areas because they allow the researcher to focus the conversation on key

areas of enquiry while also leaving appropriate leeway to participants' to explore their own definitions and subjectivities in relation to each area (Bryman, 2016; Saldaña, 2011). For example, in relation to clients' needs, a structured approach was useful in focusing clients on areas of need which may impact them (such as substance misuse, mental health etc.) but the particular subjectivities and perspectives on these issues were illuminated through the less structured conversations which followed. Wengraf (2011: 5) highlights the importance of a flexible topic guide and approach in semi structured interviews, positing that the semi structured interviewer will have to improvise about half of the questions. This proved to be true in my own experience where participants' responses often skipped between topics and time points. The general topics and key questions in the guide proved useful, but planned 'probes' often had to be amended to fit the participants response.

Throughout this process, listening was of vital importance. Wengraf (2011: 202) cites McKay et al. (1983) to identify 13 obstacles to listening in qualitative interviews. The most common obstacle I experienced during interviews was 'filtering', searching for what I deem relevant in participants' responses. This filtering proved useful in identifying key points that required further probing for clarification or elaboration. However, during transcription, it became clear that by searching for points to 'probe' around in advance, other important aspects of participants' accounts were not followed up. Through summative evaluation between waves, it was possible to revisit these areas in future interviews, mitigating the negative impact of these missed opportunities.

Nevertheless, this issue contributed to a wider weakness of a semi-structured design and of allowing participants to 'ramble'. In that, it resulted in an uneven distribution of richness across data in various areas, and for different participants. Of course, the extent to which participants focused on particular areas is likely to be representative of those areas were most prominent in their recovery. It was nevertheless a challenge in comparing between waves and across participants.

Quantitative measures were deliberately shifted to the end of topic guides so participants had sufficient time to 'warm' to the interviewer and reflect upon various relevant areas before being asked more abstract questions associated to psychometric scales exploring notions of wellbeing and mastery.

Biographical Narrative Interviews

Wengraf (2001: 111) defines a narrative interview as one "*that focuses on the elicitation and provocation of storytelling*". A biographical narrative interview focuses storytelling on the participants' life history.

Participants were invited to take part in a biographical narrative interview, which focused on their personal histories, thematically exploring their childhood, education, employment history, social relations and the incidence, origins and development of a range of needs and capabilities in their life. This data situated the influence of particular environmental stimuli on different participants. A thematic approach was taken to the topic guide, yet in line with the principles of a narrative interview, participants were given significant remit to 'ramble', skipping between themes in a chronological manner if they preferred, and going into greater depth on others. The 'in depth' nature of these interviews posed ethical questions for myself and the study (see section 4.6.3). Not all biographical interviews took place during the first stage due to the availability of participants. In addition, later interviews commonly picked up on key trends and gaps in biographical narratives.

Biographical interviews are common in qualitative longitudinal research. When used retrospectively they offer the researcher an opportunity to situate the period of study within the wider context of an individual's life. In doing so, they enable greater understanding of the impact of an intervention (Merrill & West, 2009).

Biographical interviews are promoted in relation to a situational approach (see section 3.5). In line with Wikström's situational action theory, the best way to understand the personal influences on individual's decisions are personal histories (Wikström 2014;

Wikström, Oberwittler et al., 2012). Decision making literature highlights that although objective factors influence our capacity for choice they are often mediated through our subjective understanding (see section 3.4). Therefore, the commonly cited critique of biographical narratives being objectively inaccurate is of less relevance (Merrill & West, 2009). This study was instead only interested in the subjective narratives of participants, as it was these narratives that can offer insight into the preferences which influence participants' choices.

Biographical interviews also clarify what 'success' means for that particular individual, outlining the specific set of challenges they face and establishing the 'capability' of that client to utilise the support provided by the intervention⁹. In turn, validating the priorities individuals have outlined for themselves, and offering information on the likelihood of achieving those priorities. For example, a number of participants' ultimate goals were to re-establish links with their children who were taken into state care. Understanding the circumstances in which their children were taken into care illuminates how likely it is that they can re-establish contact.

The use of biographical approaches represents an original contribution to the HF literature and to the evaluation of services targeting the MEH population more generally. The literature review undertaken in this study did not reveal any other studies which utilised biographical data beyond general needs related data. As a result, there is an inherent risk that these studies present HF clients as a more homogenised group than they are in reality.

Professional Stakeholder Interviews

Incorporating professional stakeholders in the research design is a common, even essential feature of any evaluation. In this study, case managers and service managers were invited to participate in semi structured interviews at the end of the first wave and

⁹ See section 3.5.2 under 'The Capabilities of MEH actors'

third wave. These interviews had two primary aims; firstly, to provide more information on the practical, social, political and economic context in which the service operates; secondly, to explore the service's adherence to, and knowledge of the principles inherent in a HF model.

There is contrasting evidence in the UK as to professional perspectives to HF. Some evidence suggests that community resettlement and personalised support guided by client choice and control are already central tenets of provision for many (Johnsen and Teixeira 2012). However, there is also evidence of 'responsibilisation' and exclusion for those experiencing MEH, which suggest that 'staircase' models informed by a treatment first approach dominate provision for this group and offer little choice to clients (Bowpitt, Dwyer, Sundin, & Weinstein, 2014; Dwyer, Bowpitt, Sundin, & Weinstein, 2014; Whiteford, 2010).

From a clients' perspective, once they are housed, the service essentially becomes the case manager who supports them. As such, the opinions and views that underpin the working practices of those case managers are likely to have a profound impact upon the level of choice and control available to clients.

It was also important to include the views of service managers, as it is their responsibility to ensure adherence to the HF principles, as well as dynamically defining those principles to the particular local context and client group (Atherton & McNaughton Nicholls, 2008). These service managers also provide a wider view of the service, going beyond the essential but narrower perspectives of individual clients. In his HF Europe guide, Pleace (2016) notes the importance of gaining a broad picture of how the service works, and particularly how outcomes are achieved. Alongside immersion in the research context and ethnographic methods¹⁰, qualitative interviews with stakeholders "allow examination of the 'backstage' happenings and unexpected consequences taking place in programs" (Padgett, 2017: 10).

¹⁰ See section 4.4.2 under 'Ethnographic methods'

Conducting interviews at the end of the first stage allowed emergent themes from the 18 client participants to be explored further. In turn, it was possible able to explore how representative these experiences were for the population more generally.

Innovations and Developments for Wave 2

The flexible nature of a qualitative, longitudinal design enabled key innovations to emerge from wave 1. During the ethics process there was health and safety concerns which prevented me from interviewing participants in their homes alone. As participants' new flats were supposed to be the context in which their recovery was taking place, it was essential to at least have the option of interviewing participants there, making it easier for them to contextualise their responses (Valentine, 2005).

The compromise that was reached was to interview participants in their homes, alongside their case manager. Although, initially understood as a less desirable compromise, the measure enabled two key methodological innovations. Both of these innovations were realised during the first stage as I travelled to, and conducted interviews as part of case manager's appointments with participants.

Conducting interviews during appointments allowed me to observe the interactions between client and case manager including the power relations at play. As we travelled to appointments, conversations would naturally turn to the clients we were about to visit. In turn, case managers would often give me updates on clients' progress, the issues they were facing, and people that were significant in their lives. This rich ethnographic data was also being gathered as I approached case managers with the aim of recruiting participants. Kusenbach (2003) discusses the use of such data in what he terms 'street phenomenology'. He notes that the approach is particularly useful in gathering and validating data for 'hard to reach' groups.

The issue I faced was that I was acquiring this rich ethnographic data without appropriate consent from participants. Having already received the information, it was going to affect my interactions with participants, and my analysis of their progress.

Therefore, I gained additional ethical approval¹¹ and sought informed consent from participants' to begin gathering and using this information. Further, I used the third stage of data collection to go through all of the ethnographic notes with participants, giving them the option to correct or remove any elements they disapproved of (see section 4.4.3).

After the first wave, topic guides were amended to focus enquiry on the areas of most relevance to participants. Interviews were transcribed and thematically analysed using NVivo Qualitative Data Analysis software and according to broad outcome domains, however, sufficient flexibility was enabled to also explore emergent themes which influenced participants' capacity for choice and control. In the first instance, this thematic analysis was undertaken on a participant by participant basis. This analysis formed the basis of case histories that were developed for each participant throughout the course of the research (see section 4.4.2).

4.4.2: Wave 2

The second wave of data collection was extended by one month, taking place between January – March 2016. At this time, around half of participants were undergoing periods of crisis, making interviews with them unsuitable. In the opinions of service managers and case managers, this period of crisis was attributed to the emotional and practical upheaval of the festive period. Memories of or direct contact with distant family, feelings of isolation, and gaps in service provision contributed to many clients resorting to familiar preferences involving homeless associates and substance misuse. Many participants invited associates into their flats for altruistic reasons, socialising, or both.

Retention

Pleace and Wallace (2011) note that sample attrition (the loss of participants) can undermine the internal validity¹² of a study. Extending the period of data collection posed

¹¹ Additional ethical approval was gained from 'Department of Social Sciences and Languages Ethics Committee' at Northumbria University

¹² Pleace and Wallace (2011: 52) define internal validity as referring "to the design of an evaluation ensuring that what it is intended to measure is actually being measured".

few issues for the overall design of this study and prevented attrition, enabling 15 of 18 participants to be interviewed at wave 2.

Extending the period of data collection also facilitated the use of other methods of retention. The primary method was to frequent the rough sleeper day centre in which the case managers were based and in which some participants still attended. 'Being there' repeatedly over a series of months allowed me to develop relationships with the case managers and some of the client participants. In turn, I was able to check whether participants were available to be interviewed.

It was deemed important not to abuse the generosity of participants or gatekeepers (Saldaña, 2003). Consequently, much of this relationship building involved informal chat, which did not produce useful data, but was the necessary foundation for discussions about the service and participants. The question of 'how is Jimmy (participant) doing?' was often all that was required to gain a detailed overview of their current situation. Case managers were usually very happy to discuss clients as it offered them an opportunity to offload information to another interested party. As a result, although I often had to wait for interviews, I was in fact able to gather a great deal of data from the case manager about clients' progress. This methodological approach is something that could be applied to studies without longitudinal designs. However, the approach was strengthened by repeated interactions with case managers in which we mutually developed our knowledge of clients. The case managers would share information about clients' progress and I would share insights from the data I had collected.

Another method used to improve retention was to offer £10 vouchers for participation at each wave. Offering vouchers is a common method of thanking participants for their time (Ensign & Ammerman, 2008; Grant, 2011). However, in a longitudinal project, vouchers also act as a means of incentivising participants, as once a voucher is offered in the first wave, it is known to be available in successive waves.

For some, offering incentives to 'vulnerable groups' is a controversial ethical decision (Hutz & Koller, 1999). Central to this controversy is the idea that offering incentives can lead to issues of coercion and corruption of judgement on the part of the potential participant (Grant & Sugarman, 2004). Indeed, the use of monetary payment has been shown to have positive effects on participants' willingness to take part in research (Bentley & Thacker, 2004). However, the use of incentives, particularly in non-monetary form, is generally thought innocuous. This is unless the risk of the research is particularly high, the research is degrading or the participants' aversion to the research is strong (Grant & Sugarman, 2004). This study did not meet this criteria, and so offering a voucher at each wave was not seen as an ethical concern. To the contrary, asking participants who have faced exclusion through the life course, and who live in situations of poverty to participate in a university study without some form of reward is arguably more unethical.

Interview Themes

The second wave of interviews focused on similar themes as the first, with greater emphasis placed on those themes of most relevance to individual participants. Two sets of information were used to illuminate those themes of most relevance to participants. Firstly, case histories developed during analysis of first wave data gave an overview of the key themes for that particular participant, including the factors which influenced their capacity for choice and control. Secondly, the updates I received from case managers allowed me to draw upon the present factors of relevance in participants' lives.

These two sets of information allowed me to personalise the interviews to some degree. Personalising interviews based on my own interpretation of key themes and on case manager perspectives does pose the risk that participants are not given sufficient freedom to discuss issues of most relevance to them. Therefore, all outcome domains were still covered to some extent. However, the personalisation of interviews proved successful in gaining richer data on the often complex and individualised nature of the issues facing participants. This connection between individual level analysis and

developing research design is a key strength of Qualitative Longitudinal research (Thomson, 2007; Thomson & Holland, 2003). It is important to reiterate here that the study was concerned with inherently complex and subjective notions of choice, control and success. In order to capture these, it was necessary to have some degree of personalisation.

Ethnographic Methods

According to Bryman (2015) ethnography entails the extended involvement of the researcher in the social life of those he or she studies. Specifically, an ethnographic approach draws attention to the fact that the researcher observes behaviour, interactions between others, and between self and others, and asks questions. In turn, ethnography is inherently associated to participant observation. Saldaña (2003) views largely concur, although he adds that the goal of ethnographic research is to capture the naturalistic actions and reactions to enable inferences about the way they are thinking.

Alongside case manager updates and data gathered during informal 'walking interviews' with case managers (Kusenbach, 2003) I also employed overt ethnographic observations of the interactions between participants and their case managers. A limited number of studies have employed ethnographic approaches in HF research (Padgett et al., 2016). With specific reference to homeless adults, Padgett (2015) promotes the use of observations alongside interviews, arguing that they allow for deepened perspectives on participants' lives. Padgett acknowledges that these data collection methods are labour intensive. However, by integrating multiple forms of data the researcher is able to create a more complete portrayal of participants' lives as they pursue a more stable life.

Furthermore, Tiderington (2015) discusses the use of ethnographic approaches when exploring the relationship between case managers and clients in homeless services. She notes that observational data can reveal tensions between staff and clients where interview data does not. Tiderington's findings also highlight that clinical or therapeutic relationships were limited by staff turnover and by administrative tasks. The role of

administrative tasks also played a key role in my own observations. As many of these tasks involved wider stakeholders such as landlords and income providers I was also able to observe the interactions between participants and these stakeholders. These interactions highlighted how individuals outside of the immediate service remit can influence an individual's capacity for choice and control. They also allowed me to observe the variations in participants' capacities to personally handle these processes.

Case history development

Qualitative longitudinal studies build rich archives of data for participants, which can be handled and organised in different ways (see Richards, 2014). Case histories are a particularly useful method for managing qualitative longitudinal data (McLeod, 2003). Constructing case histories for individual participants throughout the period of data collection allows the researcher to dynamically identify and therefore explore emergent trends (Miles, Huberman & Saldaña, 2014). Individual case histories were particularly useful in this study as it is primarily concerned with highly individualised concepts such as 'choice' and 'success' within highly individualised processes such as recovery and desistance. The individual becomes the first object of enquiry, allowing specific enquiry into their experience (Holland, 2007). In turn, cross case analyses that generalises across the sample is rooted in a deeper understanding of each individual case.

The case histories developed during wave 1 were built upon in wave 2. This included another round of thematic analysis undertaken using transcriptions of the interview data collected during wave 2. Observational data was collected in the form of observational notes, which were transcribed into more detailed accounts on the day of collection. These observational notes were then referenced to a particular participant (or number of participants) to be incorporated in thematic analysis. Both interview transcripts and observational notes were drawn into NVivo as sources which were then coded under nodes to consolidate the data. Understanding the increasingly rich and complex data

which was emerging necessitated a methodological innovation. One method used to 'make sense' of this data was 'situational mapping'.

Mapping

Situational maps were created for each participant, one referencing the data from their period in HF, and one which focused on participants' biographical narratives of their lives prior to HF. Drawing upon various methods of understanding data with temporal characteristics, situational maps are essentially more complex versions of timelines. The 'pathways approach' common in homelessness research (Clapham, 2003) and the route maps utilised by Ravenhill (2012) both provided useful overviews of how temporally mapping data can offer insight into the relationship between different factors, as well as highlighting key points in individual pathways, in turn illuminating causal relationships¹³.

Exploring the key points in individual trajectories is a feature of research exploring homelessness (Clapham, 2003), desistance (Laub & Sampson, 1993) notions of personal choice (Holland & Thomson, 2009; Thomson et al., 2002), and rationality (Bengtsson & Hertting, 2014). Each of these studies operationalise Gidden's (1991) notion of 'fateful moments' to explore the critical junctures and turning points in individuals lives as a means of understanding the relationship between choice and the resulting consequences.

¹³ See section 3.6 for an overview of the 'Pathways' approach

4.4.3: Wave 3

Twelve of the original eighteen participants took part in interviews in the third wave of data collection that focused on summarising and consolidating the data collected to this point. Observations followed the approach described in earlier waves. Interviews focused on similar trends by covering a range of outcome domains, but with increased personalisation of the interview focus. The summative nature of this stage enabled me to mitigate a key ethical concern implicit in longitudinal research; closure (Holland et al., 2006). By making it clear that the study was coming to an end and summarising the findings so far participants were better prepared for the end of the study.

A key methodological innovation at this stage was to engage in a process of review with participants about their own individual case history, the reasons for this were two fold. The first was ethical; because some data had been collected from case managers and therefore required review by participants in order to ensure they still maintained control over data, which ultimately belonged to them. Secondly, that the process of analysis had been, to some extent, interpretive, relating participants personal histories to their current trajectory, and drawing relationships between key events. To ensure internal validity, it was important to return to participants with these emergent findings in order to establish how representative they were of participants' own perception. Pleace and Wallace (2011) highlight the importance are the tools being used for measurement in determining internal validity. Revisiting the data collected from participants allows review and validation of this data and the tools.

Participatory Review

Participatory approaches commonly refer to the co-production of research, with participation extending across all elements of the research (Kendon, Pain, & Kesby, 2007). However, participatory methods such as visualising data through timelines, matrices are also common features in qualitative research more broadly (Pain & Francis, 2003).

Particularly in research that seeks to increase the degree of engagement between participants and the research.

The process of participatory review described here focused on revisiting participants' case histories with them at the third wave. The process was assisted by the development of case histories throughout the first two waves of analysis (Thomson, 2007). In particular, the development of situational maps consolidated this analysis into an easily understandable form which could be used to illicit further discussion of particular events, issues, and themes.

Participants were also invited to review the events and my interpretation of the linkages between them. Importantly, situational maps only brought benefits when supplemented by discussion with the researcher. This discussion offered more information on the sources of particular pieces of data, as well as the relationships between particular domains or events.

In this study, the use of situational maps proved a very useful tool in eliciting more information from participants. Moreover, they were generally thought to be accurate representations by participants themselves. However, there were still many minor corrections and clarifications made by participants. These clarifications often proved a useful methodological tool in themselves, prompting further discussion of outcome domains and the causal relationships between the facilitators and barriers participants faced. For example, in one interview clarification of the age at which one participant went into the army elicited previously unshared information about the origins of their alcoholism.

Professional Stakeholder Interviews

As part of the summative nature of wave 3, a second series interviews were also undertaken with case managers and service managers. A stakeholder from Newcastle City Council was also interviewed to situate the data collection in the wider context of service delivery for this group.

For case managers and service managers, the interviews deliberately followed the same themes as those in wave 1. The purpose was to establish any change in their perspectives, either on the principles of HF, or the capacity of the service to facilitate them. These two themes enabled more nuanced discussion of the model. It became clear that the perspectives of case managers varied not only according to their working philosophies but also according to the clients they had supported¹⁴.

4.5: Final Summative Analysis

Following the third wave of data collection, the final wave of analysis began. The first step was to analyse interview and observation data from the third wave of interviews. Participants' interviews were analysed thematically, which involved coding and categorising participants' narratives according to outcome domains and sub domains¹⁵, as well as the influences on their capacity for choice and control. Biographical interviews were coded separately according to key domains in their life histories¹⁶. This data was also consolidated into each participants' situational maps, alongside the amendments noted by participants during the process of participatory review.

Once data from the third wave of data collection had been organised, the final summative analysis could begin. As with much qualitative data analysis, the first stage was to familiarise myself with the data collected across all three stages by going through the data consigned to each of the codes in wave 1 and 2, as well as re-reading the original interview transcripts (Bryman, 2015). This also involved revisiting methodological memos that had highlighted emergent themes to ensure none of these had been lost from the analysis without appropriate reasoning.

Data from all three waves was then drawn into a more comprehensive framework aimed at pulling out the key trends in relation to 'choice', 'control' and 'success' for each

¹⁴ See section 7.2.2 for further discussion of findings that emerged from case manager interviews.

¹⁵ See section 4.2.4 under 'Outcome Measurement'. A full example of domains, sub domains and composite measures can be found in Appendix B.1.1

¹⁶ Example of Domains and Composite Measures used in Life History Categorisation can be found in Appendix B.1.2

individual participant, before comparing experiences through cross case analyses. Placing the participant at the centre of analysis is central to a longitudinal approach (Plumridge & Thomson, 2003). Doing so, allows the researcher to better understand the subjective process of that individual's life. Nevertheless, there is a need to compare across cases in order to explore relationships and trends between individual experiences (Thomson, 2007).

Once data from wave 1, 2 and 3 had been analysed for each individual participant, the data could be organised into three categories:

1. Biographical life history data, relating to the existence and extent of particular needs and capabilities, which influence each participants' capacity for choice, control and success.
2. Interview and observation data, which focused on the actual achievement of subjectively and objectively desirable outcomes.
3. Interview and observation data pertaining to environmental factors influencing the capacity for choice and control for each client.

Each of these data sets needed to be consolidated further before cross case analysis could be undertaken. The following sections outline the next stage of analysis for each.

4.5.1: Outcome Measurement and Trajectory Categorisation

Due to the broad range of the possible outcomes for MEH adults, outcomes were explored across a range of domains (see table 4.1, section 4.2.4). In order to recognise the individualised nature of recovery and desistance pathways and to explore subjective notions of choice and control, additional weighting was given to those outcomes that participants identified as personal priorities¹⁷.

¹⁷ See section 4.2.4 under 'Personal Priority Outcomes'.

This additional weighting was actualised in decisions over the overall trajectory of participants' time in HF. The use of trajectories is not completely new in evaluations of HF (see section 2.6.3). For example, Johnsen's (2014) evaluation of HF for heroin users in Glasgow conceptualised participants' progress in terms of trajectories. Johnsen's (2014: 33) categorised participants' into three trajectories (sustained positive change, fluctuating and little observable change), based on their overall direction and/or extent of behaviour change; so too "distance travelled" on their journey toward recovery from substance misuse".

In this study, trajectories were determined in a similarly observational and interpretive way. However, this process was still informed by detailed analysis. After qualitative data was coded using NVivo software it was combined with quantitative data gathered through psychometric scales.

Each set of data was combined into a single excel document for each participant which organised qualitative and quantitative composite measures according to domains of behaviour change in participants' lives and recovery (see Appendix B.1.1).

Once data for all domains, and for each wave, was organised in this manner, a decision was made over the participants' trajectory in that particular domain. An interpretive decision was then made on participants' overall trajectory, with additional weighting given to those personal priority outcomes.

The study tracked participants for 16 months. However, it is generally recognised that most recoveries from multiple and complex needs will extend long beyond this period (Terry & Cardwell, 2015). In addition, the nuanced nature of outcomes and the constant risk of set back and relapse means that claims of achieved outcomes may be assumptive. As such, trajectories were identified as a more appropriate means of measuring 'success'. Findings related to participants' priorities (5.2) and trajectories (5.3), as well as their achievement of outcomes in individual domains (5.4) can be found in Chapter 5.

4.5.2: Life History Categorisations

Unlike data from each individual stage, the biographical narrative data for each participant had been accumulated in a separate node using NVivo software. This data was coded and categorised according to domains and sub domains representative of relevant 'needs', 'capabilities' and 'preferences'. As represented in a 'situational' understanding of decision making (see section 3.5), participants' choices are influenced by the accumulation of experiences over the life course, understood as 'preferences', 'capabilities', and 'needs', each of which influence participants' personal capacity for decision making (see section 3.5.2). These domains were also representative of the areas covered in interview topic guides and in literature focused on the histories of MEH/SMD adults (Fitzpatrick et al. 2012, Fitzpatrick et al., 2015).

This data was then drawn into a framework analysis that brought narrative data together with more objective data elicited from 'Gateway', and case managers. This allowed the strengths of narrative analysis in identifying '*how people make sense of what happened*' to be situated alongside other data to also gain a picture of '*what happened?*' (Bryman, 2015). This framework essentially summarised the data consigned to codes into a format which allowed me to more easily understand the 'needs' and 'capabilities' which were of most relevance in that participants' life.

The interpretive element of the research design emerged as decisions were made about, for example, participants' subjective report of their family. This was done using a similar framework as that used in outcome measurement, with composite indicators contributing to scores in sub domains and domains such as housing, substance misuse, social relationships etc. (see Appendix B.1.2).

Biographical narrative data was also consolidated into situational maps (see figure 4.1) to explore relationship between participants' needs and capabilities over the life course.

By consolidating the data into these two summative accounts, it was possible to highlight differences in the needs and capabilities they presented when entering the study. Difference was explored in relation to the incidence of needs and capabilities, the extent to their development, and their origins. The findings which emerged are outlined in section 6.3, with more detailed analysis and discussion available in Appendix B.2.

In highlighting these differences, similarities also emerged across participants, leading to the development of a typology (see section 6.3). Each 'type' of personal history presented different considerations for the HF service, and different capacities to utilise choice in HF to achieve recovery and desistance orientated outcomes.

4.5.3: Environmental factors influencing the capacity for choice and control for each client.

Thematic analysis was undertaken at each wave on a case-by-case basis. The analysis sought to identify the environmental factors that emerged as influencing participants' capacity for choice and control, both within the service and more broadly. A key part of this analysis was to focus on participants' perceived sense of choice over housing, support, and behaviour in the HF service. Separate thematic analysis undertaken across cases contributed to the findings related to participants' general sense of choice, outlined in section 6.2.

However, the decision was taken to explore participants' capacity for choice more broadly as it was felt that this represented the type of service delivery being offered to HF clients. The service (and the HF model more generally) is reflective of neo liberal models of service provision by aiming to involve a wide range of stakeholders in the recovery of clients. Private landlords, other service providers, and residents in the destination community all have influence over the norms which surround clients, as well as the opportunities and resources they can access (see section 3.5.3). Consequently, the factors influencing participants' capacity for choice and control were first organised into categories that reflected these broad influences.

Consolidating Personal and Environmental factors influencing Choice and Control: Framework Analysis

Earlier sections have already described some elements of cross case analyses used to identify participants' trajectories towards outcomes, to categorise their capabilities and needs, and to understand the environmental factors that influence their capacity for 'choice', 'control' and 'success'.

This section focuses on the use of framework thematic analysis to understand the key personal and environmental factors influencing participants' choice and control. Framework analysis is also employed to understand the relationship between the capacity for choice and control, outcome trajectories and life history categorisations (see section 4.5.4). As Khan and Van Wynsberghe (2008:1) note, cross case analyses have a number of relevant uses:

“Cross-case analysis enables case study researchers to delineate the combination of factors that may have contributed to the outcomes of the case, seek or construct an explanation as to why one case is different or the same as others, make sense of puzzling or unique findings, or further articulate the concepts, hypotheses, or theories discovered or constructed from the original case.”

Framework analysis is a method commonly used in qualitative longitudinal research to compare across cases and themes. The method basically involves the use of matrices in which categorical variables are organised along each axis and corresponding cells are highlighted when a factor is present. In line with other studies (Thomson, 2007), Microsoft excel was used to create the framework matrices. The framework analysis in this study is summative in nature, drawing together separate pieces of analysis to explore broader trends in the factors which affect participants capacity for choice and control. Therefore, factors such as 'choice over housing location and quality' is categorised as a single variable in the matrix. In reality, this variable is representative of a number of composite measures (e.g. were participants able to view their property before moving in) which have been analysed on a case by case basis.

Figure 4.2: Example of Framework Analysis for ‘Environmental facilitators of Choice and Control’

Setting Based Facilitators of Choice and Control																
Housing and Service						Neighbourhood			Local Social Networks				Wider Service Stakeholders			
Participant	Sustained access to relevant Support services	Service Bailouts for arrears and debt	Able to move when requested	Choice over housing location and quality	Subjectively balanced relationship w/ support provider	Subjectively supportive neighbours	Perceived Norms in line with Priority Outcomes	Enabling neighbourhood resources (e.g. education/ support services)	Supportive Associates	Supportive familial support	Supportive friendships	Supportive Romantic relationship	Enabling JCP/ DWP relationship	No conditions on ESA	Enabling landlord relationship	Subjectively balanced Relationships with other support providers
Arnie																
Bev							(second prop)									
Carl																
Gary																
James																
Jimmy																
Joel																
Joseph																
Johnny													(after change of advisor)			
Liam								(before mobility worsened)								
Lenny																
Lisa																
Lyla																
Linda																
TOTAL	5	6	4	9	11	2	4	5	0	6	2	2	1	10	3	3

In the first instance, matrices were created to compare the incidence of personal and environmental barriers and facilitators of choice and control across participants, resulting in four separate matrices. Figure 4.2 demonstrates one such matrix concerned with the environmental facilitators of choice and control. Individual participants were organised along the vertical axis and emergent factors influencing choice and control were organised along the horizontal axis. If a factor was present in the analysis of that participant, then the corresponding cell was highlighted.

Once completed, these matrices allowed for observation of which factors were the most common facilitators and barriers of choice and control for participants, occurring at the intersections of factor and participant. As Miles et al. (2014) note 'you know what you display', by organising all relevant parts of the data set into matrices, and organising these systematically towards the research objectives, a more credible and trustworthy analysis is enabled.

Findings related to the environmental factors which consistently affected participants' capacity for choice and control are then outlined in section 7.2. However, the remainder of Chapter 7 focuses on the differences in environmental factors that occurred according to the life history typology discussed in section 4.5.2 and presented in section 6.3. The process of analysis which identified these differences is discussed next.

4.5.4: Cross Case Analyses of the Three Data Sets

Matrices were also utilised in the final stage of data analysis, which involved comparing across the three data sets:

1. Typology of participants' biographies, focusing on particular issues and capabilities.
2. Categorisation of outcome trajectories.
3. Personal and environmental factors related to participants capacity for choice and control.

This allowed for exploration of the relationship between choice, control and outcome trajectories. Similar matrices were used as in the first set, but participants were categorised and ordered by either their life history 'type', or their outcome trajectories, with two matrices set up for each. One matrix plotted facilitators of choice and control against either needs categorisations or outcome trajectories, and another plotted barriers of choice and control against either needs categorisations or outcome trajectories.

By looking for similarities and differences across categorisations it was possible to observe the overall number of facilitators or barriers associated with each categorisation. This proved useful, as it was clear that those with more severe needs faced more barriers and experienced less facilitative factors. The same was true for outcome trajectories, those with more positive outcome trajectories facing less barriers and having more facilitators of choice and control.

In order to explore the incidence of particular types of barriers and facilitators for different groups, repetitions were identified. In other words, which particular barriers and facilitators were most common in life history types or outcome trajectories. This was important because not all barriers and facilitators had the same impact, so simply looking at the overall number of each would not be sufficient. In addition, some barriers and facilitators would commonly come with others, looking for repetitive relationships between barriers and facilitators in particular categorisations proved very useful in identifying how these related.

As a final step, summaries of the emergent findings were written for each categorisation. These summaries enabled me to draw together the trends and findings for that categorisation, as well as how they compared with others.

Building on the series of summaries written at each stage, all findings were summarised in one document, before returning to the original coding of the case histories, and the original data itself in NVivo to compare the findings. This proved a simple, but

very useful means of validation, by rooting the findings back in the original data to ensure that during the process of analysis was reflective of the experiences of participants.

4.6: Ethical Reflections

As evidenced above, ethical considerations are discussed throughout this chapter with reference to the particular methods and approaches used in sampling, data collection, and analysis. However, it is also worth drawing out separately two key ethical concerns for this study.

It is first worth highlighting that I have received ethical approval under Northumbria University Ethics guidelines. As Joel was in prison at the second wave of data collection in this project, I also went through the 'National Offender Management Service' research approval process in order to interview Joel in prison.

4.6.1: Consent

The first ethical concern was around consent. Cloke, Cooke, Cursons, Milbourne, & Widdowfield (2000) highlight informed consent as a key ethical concern for studies working with vulnerable homeless populations. In longitudinal research, this issue of concern may be exacerbated. The nature of qualitative longitudinal research is that it involves numerous waves of data collection. Subsequently, consent cannot be thought of as a one-off request in the initial recruitment of clients. Instead, informed consent is a process, necessary throughout all phases of the research, and involving continuous consultation with participants (France, Bendelow, & Williams, 2000). Essential in this process was to consistently remind participants of their capacity to withdraw all or some of the data they had offered at any point in the research process. The flexible nature of the qualitative design also means that the focus of the research may shift slightly from one wave to the next (Holland, Thomson & Henderson, 2006). Although the broader aims of the research did not change, the specific focus of interviews did. As such, in addition to an 'easy read' research information form that summarised the general aims and methods of

the research, the topic guide was discussed with participants prior to the interview at each stage.

Nevertheless, ethical concerns around consent manifested in very real terms during interviews at the second and third stage with a small number of participants asking *“What’s this all about again?”*, even after the research was explained to them at the beginning of the interview. At this point, the interview had to be stopped, so the research could once again be explained to the participant to ensure that the consent they offered at the beginning of the interview was ‘informed’.

A final concern worth noting centred on whether participants could offer informed consent when intoxicated. With individuals who have substance dependencies there is a difficult balance to strike to ensure they are in a mental state in which they can make an informed decision about consent. Alcoholics need alcohol to function, asking an alcoholic to not drink at all on the morning of an interview may hinder their capacity to offer consent. However, if they are too intoxicated they also cannot offer consent. As such, I had to make decisions alongside participants, and case managers about the suitability of participants to be interviewed and to offer consent. The most common decision was to err on the side of caution and return at a later date if participants displayed any degree of intoxication.

4.6.2: Confidentiality and presenting case history data

Confidentiality was a key ethical concern for this study, in particular, in the collection and collation of individual case histories. As Holland et al. (2006) notes, this data can accumulate a unique ‘fingerprint’, identifying that individual. As noted in the section above, participants were reminded at each stage that the data was ultimately owned by them and that they could chose to delete or remove any element they wished. However, whether participants could remember all the data they offered over three waves of interviews is dubious, in addition, some data came from case managers. To ensure participants could have the best opportunity to review the data used in the study

respondent validation was used (Torrance, 2012). This referred to analysis used in the first two waves being revisited with participants at the third stage, giving them the opportunity to amend or remove any data, for any reason¹⁸. Of course, even after reviewing data, participants may change their minds, and once the data is formulated into a thesis or a publication, it is in the public sphere, and more difficult to remove. Therefore, it was essential to anonymise case histories as much as possible during analysis.

4.6.3: 'Researching Violence, Trauma and Pain' – Reflections on the emotional impact of researching adverse life conditions

Conducting in depth, qualitative research with MEH adults will always have an emotional aspect (see section 3.5.2). Indeed, the qualitative method is directly concerned with emotions through its wider concern for the meaning behind actions (Saldaña, 2011). However, by drawing out these emotions, there is a risk of emotional harm to the researcher and the participant (Liamputtong, 2006)

For participants who have lived through these traumatic and adverse circumstances, there is a risk that re-visiting these emotions may bring damaging consequences for mental health, and ultimately their HF tenancy (see section 3.5.2). As a result, a number of contingencies were put in place to prevent adverse emotional effects brought on by discussing adverse and traumatic life conditions. The first of which was to disclose the topic guides used in both interviews to case managers in advance of interviews. This allowed case managers to note particular discussion topics which may cause emotional distress and should be either discussed sensitively or not at all. As case managers may not be aware of all topics which could prove sensitive, verbal consent was sought from participants for a historical interview in general, and in relation to each of the domains which participants were to be asked about.

Upon signs of emotional stress from the participant, or when a potentially sensitive topic arose, I reminded participants that they could disclose as much or as little as they

¹⁸ More discussion of this can be found in section 4.4.3 under 'Participatory review'

wished, and that they had ultimate control over the data, even after the interview was conducted. Following the interview, participants were reminded of the support available to them if adverse emotional reactions emerged after the interview, both through their case manager and other services such as the Samaritans. If case manager were present they could arrange to contact participants after the interview. Not all interviews took place with case managers in the room, indeed, some wished to be interviewed separately. In this case, I liaised with case managers after the interview, with participants' permission.

Of course, these contingencies are essential. However, it is also important to recognise that discussing adverse and traumatic emotional experiences is not inherently dangerous. That many of these participants are still alive and able to take advantage of a HF tenancy is testament to the resilience they have shown over many years of emotional pain and exclusion. In turn, a number of participants noted that discussing these issues was in some ways therapeutic, particularly if they lacked the social connections with which to talk about their emotions. In interpretive, qualitative research the goal is gain an empathetic understanding of the participant. In turn, I sought to be as impartial as possible and to make this as clear as possible to the participant prior to, and during the interview. In this way, the interview can be seen as 'safe space' in which participants can disclose and discuss experiences and emotions without conditions or consequences. DeVerteuil's (2004) had a similar experience, he notes that being an 'outsider' in a homeless service situating him as a form of counsellor, allowing deeper insight and discussion. In turn, Liamputtong (2006) highlights how in depth interviews in particular can enable the time required to develop an intimate discussion.

However, there is also a risk to the researcher of discussing the traumatic experiences of others in such depth. This is particularly true when these experiences include childhood sexual and physical abuse, and often graphic descriptions of violence and aggression (Coles & Mudaly, 2010; Coles, Astbury, Dartnall, & Limjerwala, 2014). It was the biographical narrative interviews that had the greatest emotional impact on me,

affecting my mood long beyond the interviews themselves. However, this prolonged emotional effect also elicited deeper reflection on the experiences of participants. It is recognised that emotions, particularly negative emotions impair our capacity for rational, deliberative thought¹⁹. As such, by exposing myself to negative emotional reactions I was able to gain (to a small extent) a deeper understanding of how emotions may influence their rationality. Immediately after conducting possibly the most challenging interview emotionally, I reflected:

“Just from hearing her story I was angry, upset, and ready to shout at any one who crossed me in the slightest way. If I felt this way after just 2 hours listening to her life it is no wonder that so many of multiply excluded individuals are often angry, they are constantly living through these stressors. This emotional stress only developed further after I went to the pub later, I became more angry and more disillusioned, which led to more drinking.”

Like many of my participants, I reverted to familiar coping mechanisms when faced with emotional stress, substances. Of course, hearing the challenges faced by participants can never allow me to fully understand these experiences, or the behaviours which follow. However, in a small way it does offer me insight into the rationality in seemingly irrational behaviours.

4.7: Conclusion

This chapter has outlined the methodological approach employed in the study, as well as its ontological and epistemological underpinnings, with the key strengths, weaknesses, and original elements highlighted throughout.

The study possessed elements of both a deductive and inductive approach. In the first instance, the study was primarily deductive, with the research questions and methodology to being largely guided by a series of literature reviews. These reviews highlighted both realist and interpretivist ontological and epistemological perspectives as

¹⁹ See Turner and Stets (2005) for a summary of evidence.

being appropriate for both measuring outcomes and exploring notions of 'choice' and 'control' inherent in the HF model. These perspectives manifested in a qualitative bias in the research design, but with quantitative elements utilised as a supplementary and comparative aspect to the qualitative data.

The inductive aspects of the research primarily emerged from the use of a qualitative, longitudinal approach as a methodological framework. The key strength of a longitudinal approach in exploring change over time was essential for a research project which focused on intertemporal choices and processes of recovery; fraught with set back and relapse. Utilising such an approach enabled analysis to occur alongside data collection, informing the areas of inquiry and the type of methods themselves.

This summative analysis at each wave actualised the potential for flexibility offered by a qualitative longitudinal approach and enabled considerable innovation to occur during the research process, lending inductive characteristics to the study. These innovations emerged from methodological and ethical considerations, as well as emergent findings from analysis at each wave. Although the research continued to rely on interviews during three waves of data collection, it also increasingly shifted towards the use of methods and approaches usually associated with ethnographic design. This process was at first organic, emerging as a pragmatic response to the challenges of retaining participants. However, once the richness of the data was realised, the use of case manager updates and overt observations became a key strength of the research, allowing gaps between interviews to be filled.

The use ethnographic approaches to combine methods of retention and data collection proved to be extremely useful in gaining a more substantive picture of participants' lives. A key methodological innovation was the use of mapping as part of each participants' case history. This enabled me to see the temporal process of change as well as the interaction between key events and domains in the lives of each participant.

The final summative process of analysis consolidated the data in individual case histories into three key data sets before comparing across these. Cross case analyses was undertaken using a framework approach, which enabled comparison between participants. Similarities and differences across participants allowed categorisations to be drawn out, demonstrating considerable variation in the capacity for choice and control, outcome trajectories, and life histories. Further framework analysis across these three data sets enabled me to explore the relationship between 'choice', 'control' and 'success'.

In summary, the methodology outlined in this chapter has allowed me to collect new and innovative data that offers insights into the role of choice and control in enabling clients to achieve 'successful' outcomes in HF. In subsequent chapters, these insights will allow important contributions to gaps in HF literature, and identify new critical ways of understanding notions of choice, control and success in HF.

5: Establishing and Measuring 'Success': Outcome Priorities and Trajectories

5.1: Introduction

As highlighted in reference to 'success' in HF literature (see section 2.6), the possible outcomes for MEH adults are broad and interdependent. The achievement of outcomes in one area (e.g. retaining independent housing), is commonly thought to lead to other improved outcomes in other domains (e.g. health and wellbeing). Given the dynamic nature of recovery and desistance processes, it is often very difficult to say with any authority that outcomes have been definitively achieved, and with even less authority that they will be sustained. Furthermore, processes of outcome achievement are often long. Although some may experience miraculous 'turn arounds', most will experience gradual processes of change, fraught with set back and relapse (see section 2.7.3). For these reasons, longer term outcomes related to substance misuse recovery, mental health recovery and offending desistance are less forthcoming in HF studies which evaluate over the short to medium term.

Amidst the broad range of possible outcomes, there are those that are more important to individual participants. Given the individualised nature of recovery and desistance processes, as well as the primacy given to choice and control for clients, it is deemed important to incorporate some degree of personalisation in the measurement of outcomes (Henwood et al., 2015). Further, to understand the 'choices' of participants, it is first important to establish an idea of their goals (or priorities) (Bengtsson & Somerville, 2002). Doing so allows a picture of the extent to which they are able to utilise the mechanism of choice to pursue their own version of a positive and meaningful life. Therefore, the chapter begins by outlining participants' personal priority outcomes. Although participants' priorities are given primacy, section 5.2.3 identifies that these priorities are dependent on the achievement of other outcomes.

Section 5.2 then outlines the extent to which participants are able to achieve or move towards outcomes across all domains, with additional weighting given to participants' priorities. This study is bound by familiar time restrictions and could only follow participants' progress for 16 months. Although, this represents a similar period as some other HF evaluations (e.g. Patterson et al., 2013), it was not long enough to observe achievement of such long-term outcomes. Therefore, and as detailed further in section 5.3, this chapter measures outcome achievement in terms of trajectories²⁰. What differentiates this study from others is the detail of data collection, involving detailed interviews and ethnographic methods over three waves.

As well as exploring trajectories, scope is left within the research design to establish whether participants have progressed towards outcomes in particular domains. Section 5.4 then draws back to the outcome domains, establishing the extent to which 'success' was achieved across all participants in each domain. As in participants' general outcome trajectories, considerable variation is found in participants' capacity to progress towards outcomes in particular domains.

5.2: Personal Priorities

Given the importance placed on personalisation within the HF model, recovery and desistance agendas more generally (Corney et al., 2014), and within Sen's (1993) capabilities approach²¹, it is essential to incorporate the personal priorities of participants themselves. In particular, this study is interested in notions of 'choice' and 'control' and how they relate to notions of 'success' in HF. In order to establish whether participants are able to reach a subjectively desirable notion of success, it is important to establish what the term means to them.

²⁰ See section 2.6.3 for an outline of other HF studies which have employed trajectories.

²¹ See section 3.5.2 under 'Capabilities' for a discussion of Sen's approach.

5.2.1: The nature of participants' outcome priorities

Table 5.1 shows the outcome priorities for those fourteen participants who participated in at least two interviews through the course of the study, and who retained contact with the service throughout the study period. These conditions allowed the researcher to revisit priorities and ensure they had not radically departed from those set out at wave one. Of those participants discounted from this part of analysis, three 'disappeared' from service contact and their HF accommodation, and one disengaged with the service and study after the first stage whilst maintaining their accommodation.

Table 5.1: Participants' personal outcome priorities for the duration of the study (16 months)

<u>Participants</u>	<u>Priorities (for study duration)</u>
Arnie	Sustain sobriety (after detox), stop offending (theft), stay close to "homeless family"
Bev	Gain control of alcohol use, start some form of education, move closer to children and see them more regularly
Carl	Retain flat, start maths course, volunteer at gardening project, become employed
Gary	Retain flat, separate from homeless associates, pursue career in music
James	Retain flat, reduce drug use, separate from homeless associates, become employed, begin saving money (no specific plan for spending)
Jimmy	Retain flat, reduce alcohol use, move to bungalow, prepare will in testament to reduce burden on family
Joel	Retain flat, maintain control over mental health problems
Johnny	Continue to reduce methadone script, stop other drug use, improve physical health (go to gym), maintain increased contact with parents and brother, become employed
Joseph	Maintain control over depression, don't "slip back" to lifestyle while homeless (rough sleeping, high alcohol use), gain control over alcohol use, pass driving test.
Liam	Retain flat
Lenny	Retain flat, reduce alcohol and drug use
Lisa	Sustain sobriety, reduce methadone script, look after expectant child

Table 5.1 continued

Lyla	Separate from homeless associates (including negative romantic relationship), overcome physical and mental health problems, become employed
Linda	Retain flat, gain control over alcohol use (“no binges”), start some form of education, become employed

As shown in table 5.1, participants’ outcome priorities varied according to what they wanted to achieve in their new independent accommodation. Some (such as Liam) had very few priorities, whereas others (such as James and Johnny) had many. Some had less familiar priorities such as passing their driving test, or pursuing a career in music. In overcoming substance misuse some wished to “gain control”, others wished to “sustain sobriety” they had achieved and others wished to reduce.

The extent to which participants had considered their priorities also varied. Some had very clear ideas about what, for instance, gaining control over substance use would mean. For Linda, this meant not engaging in “binge” drinking. For others, it was less clear, for example Bev noted:

“It’s either stay off the drink completely, or, I’m like, I wonder if I got a job, I’d be probably ill for the first days cos I wouldn’t be able to drink through the day, but then I could just drink on an evening or a weekend, but it would keep us busy...”
(Bev, Wave 1)

Nevertheless, clear trends emerged across participants’ responses, namely that they were generally *ambitious* and *deliberative*. Contrary to conceptions of these individuals as ‘chaotic’, caught up in affective pursuits, they were able to formulate clear ideas of what they wanted in the future, even incorporating outcomes such as employment. This evidence supports the use of choice to enable the pursuit of longer-term outcomes by demonstrating the participants’ capacity for deliberative, intertemporal thought.

In turn, participants demonstrated the capacity to be deliberative, sequencing their outcomes. In line with White's (2007) definition of recovery, participants' priorities focused both on overcoming 'negative' behaviours (needs) often seen as holding them back from pursuing more 'positive' behaviours and activities (capabilities). Table 5.2 shows how participants' outcome priorities were commonly sequenced according to primary, short term outcomes and secondary, medium term outcomes, each contributing to the achievement of long term outcomes which represented participants' own conceptualisation of 'success'. These priorities are ordered vertically in each column to demonstrate those that were most commonly expressed.

Table 5.2: Participants' personal outcome priorities, sequenced, and ordered according to how often each was stated

<u>Initial Priority/ Priorities</u> <u>(no. of participants)</u>	<u>Secondary Priority/</u> <u>Priorities (no. of</u> <u>participants)</u>	<u>Ultimate Priorities</u> <u>(conceptualisation of</u> <u>'success') (no. of</u> <u>participants)</u>
Reduce/ gain control of substance use (8), Retain independent accommodation (8)	Engage in education (3)	Gain employment (6)
Separate from homeless associates (4)	Improve Physical Health (2)	Develop relationship with children (2)
Reduce Methadone Script (2)	Engage in volunteering (1), Move independent accommodation (1), Improve Mental Health (1), Reduce offending (1)	Save Money (1), Prepare will (1), Improve Mental Health (1), Retain independent accommodation (1), Reduce/ gain control of substance use (1), Retain "homeless family" (1), Develop relationship with family (1)

As shown in table 5.2, the most common sequencing of priorities was to reduce or gain control of substance use and retain independent accommodation, before engaging in education, and finally gaining employment. It is perhaps unsurprising that gaining employment was the most common conceptualisation of long term success for participants. In British welfare policy and social norms more broadly, employment has been increasingly positioned as gateway to greater social and economic independence and inclusion (Dwyer, 2004)²². Although participants may not be explicitly aware of contemporary trends in welfare policy, they have been recipients of welfare for long periods, engaging with services that commonly have the end goal of reducing substance misuse, gaining and retaining housing, and ultimately reaching employment. Although, not all participants expressed a desire for employment, the top priorities of all were generally in keeping with traditional outcomes for this group (e.g. developing links with family, improving mental health). Only Arnie's final goal of retaining contact with his "homeless family" may contradict this trend. Section 5.2.2 considers further the similarities and differences between participants' personal priority outcomes and policy outcomes.

5.2.2: Personal Priorities vs. Service Outcomes

As outlined in section 2.8.2, the service's outcome category were broad, outlined according to five categories. Balancing participants' goals with those of the service is a clear concern when trying to afford clients' choice and control over the support they receive (Bowpitt et al., 2011; Pleace, 2012). Table 5.3 shows how participants' priority outcomes aligned with the service outcome categories.

²² See section 3.5.3 under 'Opportunities and Resources'

Table 5.3: How Participants' Priority Outcomes fit with Service Outcomes

<u>Service Outcome Category</u>	<u>Participants' Priorities in line with Service Outcome Category</u>
<i>'Economic Wellbeing'</i> , which refers to securing income, including accessing benefits as well as reducing debt.	Gain employment (6) Save Money (1) Prepare will (1)
<i>'Enjoy and Achieve'</i> , which refers to engagement in meaningful activities such as education, volunteering, and employment. This outcome category also refers to (re) engaging with positive social networks such as family, friends or other services.	Gain employment (6) Engage in education (3) Separate from homeless associates (4) Develop relationship with children (2) Develop relationship with family (1) Engage in volunteering (1)
<i>'Be Healthy'</i> , which incorporates widely defined outcomes around physical health, mental health, wellbeing, substance misuse, abuse, and exploitation.	Reduce/ gain control of substance use (9) Reduce methadone script (2) Improve mental health (2)
<i>'Stay Safe'</i> , which generally refers to adhering to legal and social norms set out in the tenancy agreement and legislation. As such, the service aims to prevent clients from engaging in or being victims of crime. Self-harm is also noted here, although it may have a closer relationship with 'being healthy'.	Retain independent accommodation (9) Move independent accommodation (1) Reduce offending (1)
<i>'Make a Positive Contribution and Improve Wellbeing'</i> , which explicitly notes greater choice and control over support and treatment as an outcome. This also refers to clients engaging on a wider level in their destination community.	Gain employment (6) Engage in volunteering (1)

Table 5.3 shows how participants' priority outcomes are largely in keeping with the broad goals of the service. Of course, the service's goals are very broad, arguably making them easier to fit the more specific priorities of participants into, but, they are also focused on progression towards wider goals of social inclusion and independence. The relatively sparse literature on priorities of homeless adults generally suggests that their priorities are rooted in affective notions of getting by, rather than the long-term goals set by services (Busch-Geertsema, 2002; Dwyer et al., 2011; Helfrich & Chan, 2013). This study does not challenge these findings, as many participants' retrospective accounts of homeless settings were similar.

Although, this study did not gather data on participants' priorities prior to HF, while in homeless settings, many retrospectively spoke of being 'lost' in an affective lifestyle:

"Basically in the hostel, cos I was, the time before I was in the hostel I was just being an arsehole, gannin around with all the rest of them just getting wrecked all the time".

(James, Wave 1)

"I was still in heat of all the madness and I was still using all the drugs and that. So like, just cutting out the drugs like that, just phow, its been a bit, pheew, bit madness trying to cope and that."

(Lisa, Wave 1)

These retrospective accounts suggest that HF may offer homeless adults an opportunity to see longer-term outcomes as possible, in turn representing a 'fateful moment' (Giddens, 1991) or 'turning point' (Clapham, 2003) in their pathway. This suggests that HF does provide participants with what they see as a realistic foundation for positive change. However, although an essential resource (Clapham, 2010)²³, independent housing was not the only factor that influences participants' capacity to enact long-term positive change in their lives. As shown in table 5.2 (sequenced priorities)

²³ See section 2.7.1 for further discussion of the importance of independent housing as foundation for pursuing outcomes

outcomes are often mutually dependent on each other. Section 5.2.3 explores this interdependency further.

5.2.3: Mutual Dependency of All Outcomes

Within participant's accounts, there was a clear recognition that in order to achieve one long-term goal then they would also have to achieve other, shorter-term goals. In this way, they demonstrated some recognition of the importance of intertemporal choices (Berns et al., 2007)²⁴. Short-term goals were most commonly related to overcoming needs, which, as in definitions of recovery were seen by participants as hindrances to a personally fulfilling life (Anthony, 1993; White, 2007)(see section 3.2). In line with desistance and recovery literature, participants saw positive social roles and rebuilding links with family as key priorities in the long-term:

“Well I need to get off the drink first. I can't see my kids unless I get off the drink completely. I can see me daughter, me 2 year old but not me sons.”

(Deira. Disengaged after Wave 1)

“And I think like ya nar, people in me family have said this for a long time, you're only going to do this [stop taking drugs] if you do it for yourself, so..erm.. so im always sort of thinking that as well.. but my main reason for myself is to get together for me mam.. cos me mam and me dad have done everything and I think it's time to give a little bit back “

(Johnny. Wave 1)

“I want a few grand in the bank by the time im 30, ya nar what I mean, and it's not gonna happen if I'm in hostels and things like that.”

(James. Wave 1)

However, overcoming needs such as substance misuse, mental health issues and offending behaviours can represent long and challenging processes themselves.

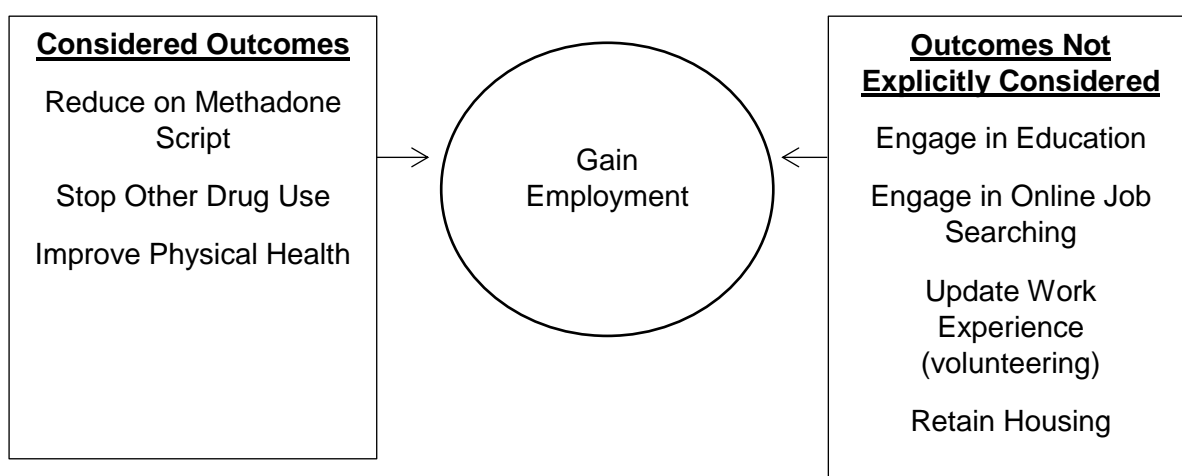
²⁴ See sections 3.2 and 3.6 for further discussion of intertemporal choices.

Interestingly, positive social networks and pro social roles are often understood as supportive and protective factors in desistance and recovery (Topor et al., 2006)(see section 3.5.3). However, many participants first wanted overcome these issues before making contact with social networks or pursuing pro social roles. For these participants, this represents a paradoxical situation in which those factors that may support recovery and desistance are not achievable until reduction in substance misuse has already been achieved.

As well as this paradox, participants did not always fully recognise the mutual dependency of all outcomes when outlining their priorities. For example, six participants noted that they wanted to gain employment, yet only three of these acknowledged that they would need to engage in any education prior to this, and only one noted volunteering. Given the limited education and employment experience it is likely that some form of education may be required prior to employment²⁵.

Figure 5.1 takes Johnny as an example. Johnny was among those who demonstrated the greatest levels of deliberation in noting his outcome priorities and their sequencing. However, he failed to consider some important outcomes he would probably have to achieve in order to reach his long term priorities.

Figure 5.1: Factors that may facilitate Johnny's pursuit of employment



²⁵ See Appendix B.2.2 for further discussion of educational histories and employment experience of participants.

Although Johnny did consider that he would probably need to reduce his prescribed and un-prescribed substance use, and improve his physical health before gaining employment, he neglected arguably more pertinent priorities such as updating his skills and experience through education and volunteering, and retaining housing. In later stages Johnny did become aware of these other outcomes on which his long term goals were contingent. As such, although collecting and measuring progress towards personal priorities was important, it was also important to measure progress towards other outcomes. To do so, a range of composite measures were drawn into wider domains and sub domains as a means of measuring progress away from needs and towards capabilities associated with a positive and meaningful life. The domains and sub domains used can be found in section 4.2.4, and a full list of composite measures can be found in Appendix B (B.1.1).

As well as the mutual dependency of different outcomes, there is also another reason to measure outcomes across a range of domains. In gathering participants priorities in the first wave of data collection, there is a risk that they may have simply repeated popular notions of 'success', rather than truly considering what they want in their own lives. Section 5.2.4 considers this risk briefly.

5.2.4: Performativity and Priorities

All participants had been in homeless situations for at least 2 years prior to entering their HF tenancy. As such, they all shared experience of being supported through models guided broadly by a 'treatment first' philosophy (see section 2.2). Therefore, the extent to which participants have been encouraged to favour these priorities emphasised by a 'treatment first' philosophy and wider social norms is important to address.

It is largely inescapable that some degree of performativity is represented in the responses of participants as their long histories of homelessness and engagement in other services means that they are likely to have been conditioned to respond in certain

ways to questions about goals for the future in order to gain access to accommodation and support.

The methods used to mitigate the impact of performativity are outlined in section 4.2.4.

5.3: Trajectories

Trajectories were identified through a process of both mapping individual 'routes' in HF and recording progression towards outcome domains²⁶. As highlighted in section 5.2.3, the achievement of personal priorities and other outcome domains were mutually dependent. As such, all outcomes were measured together with additional weighting given to domains or sub domains which were identified by participants as personal priorities. Outcomes for each domain were identified using composite measures which were recorded at each wave of the study. The overall trend in each sub domain and domain was identified and colour coded using a traffic light system. A judgement was then made on the trajectory achieved in each sub domain and domain, and therefore the overall trajectory of the participants' progress towards outcomes in the duration of the study.

5.3.1: Participants' Outcome Trajectories

It is first worth noting that no participants' situations worsened during the study. At worst the same behaviours and needs that were apparent in participants descriptions of their time in a homeless setting continued. There is a risk that alongside the rapid rise and widespread promotion of HF, that the model is seen as a panacea (Kertesz et al., 2009). This is particularly true in a context in which traditional approaches equate independent housing to success. Service managers and case managers expressed that they felt an expectation in the city that if individuals were going to be housed, the service must also be able to ensure they were successful and did not cause difficulties.

²⁶ See section 4.5.1 for further discussion of the process of analysis

“The expectations of what should happen, they may be what they want to happen in an ideal world... when it's not”

(Service Manager)

“There almost seems like with HF we're not allowed anyone to fail ... I understand different processes, different methods work for different people. For HF, if you get into that bracket, there doesn't seem to be the acceptance that HF might not work.”

(Case Manager)

‘Treatment First’ approaches have not been able to overcome the complexity of the issues experienced by clients upon entering the service, in turn contributing to their ‘multiple exclusion’ (see section 2.3). To expect the HF approach to achieve such outcomes in the first 18 months is not in line with outcomes in other implementations, or literature on recovery and desistance more generally (see sections 2.6.3 and 2.7.3). Instead, tracking change and movement towards long-term outcomes is a more realistic approach.

Trajectories are a useful means of establishing difference between participants where objective outcome achievement is nuanced and unclear. In HF, a number of studies have used trajectories as a means of measuring life changes across a range of possible outcome domains (Johnsen, 2014; Nelson et al., 2015; Padgett et al., 2016)(see section 2.6.3).

As highlighted in section 2.6.3, each study exploring trajectories in HF has used different, albeit broadly similar categorisations. Three trajectory types were identified in this study; ‘positive’, ‘fluctuating’ and ‘static’. Table 5.4 shows the participants who experienced these three trajectory types. There was a relatively even split across the three trajectories with four individuals experiencing a positive trajectory, four experiencing a static trajectory and six experiencing a fluctuating trajectory. These findings are less positive than with Johnsen (2014) and Nelson et al., (2015) who found that the majority of their participants experiencing positive trajectories. However, they are more positive than

the recovery trajectories identified by Padgett et al., (2016), where the majority of participants experiencing no significant change, a categorisation which has parallels with the ‘static’ trajectory in this study.

Unlike other studies outlined in section 2.6.3 (Nelson et al., 2015; Padgett et al., 2016; Patterson et al., 2016) no participants were classified as experiencing a ‘negative’ trajectory. This decision was taken because, as noted earlier in this section, no participant’s situations worsened during their time in HF²⁷.

The following sections offer more information on the nature of each trajectory type, the type of outcomes moved towards or achieved, the general barriers and facilitators faced by participants in each trajectory, and a representative case for each trajectory.

Table 5.4: Trajectories of participants towards outcome domains over 16 months

Positive Trajectory	Fluctuating Trajectory	Static Trajectory
Bev, Johnny, Joseph, Lisa (4)	Carl, James. Lyla, Joel, Gary, Linda (6)	Arnie, Jimmy, Liam, Lenny (4)

Positive Trajectory

When data collection ended, four participants were on a positive trajectory, having achieved some of their priority outcomes and progressed towards others.

As Johnsen (2014) highlighted in the HF Glasgow evaluation, categorising participants as having experienced a positive trajectory is not to say that they achieved or moved towards positive outcomes in every domain, or that their trajectory was uniformly positive, instead the general trend of their trajectory was positive across the majority of outcome domains, with little evidence of fluctuation.

However, two of these participants did achieve their top personal priority outcomes. Bev developed links with her children, by the end of the study she was seeing

²⁷ Please see section 8.2.2 for further discussion of the differentiation between ‘negative’ and ‘static’ trajectories.

them daily and they were regularly staying over at her flat. Lisa continued to desist from any harmful behaviour and raised her new born son through the course of the study. By the end of the study child social services decided that monitoring visits were no longer required. This represented a major success for Lisa, who while in a homeless situation had regularly engaged in heroin use, 'street culture' and rough sleeping.

Johnny was not able to reduce on his methadone script but did stop his other drug use by the end of the study. In turn, he did not gain employment but did engage in a college computer course to allow him to engage in formal job searching. He established new friendships during his time at college. Both his job searching and his computer course were mandated by his Jobcentre advisor, but were also in line with his priorities. This is not to say Johnny's relationship with the Jobcentre was without issue, as discussed in section 7.3.1. Joseph demonstrated improvements in mental health, as well as a reduction in, and greater control over his alcohol use while faced with considerable challenges associated to his ESA payment being sanctioned and contact with formerly homeless associates²⁸.

Bev, Johnny and Joseph all continued to engage in regular substance misuse, albeit in a more controlled manner than when homeless. For Bev and Joseph their alcohol use began when they woke up and continued throughout the day. Reducing the potency, restricting the times of day at which they drank represented considerable changes for each.

"I have had days when I've drank really early and that. I don't do that now ... it's not like in the morning or nothing ... I've noticed if I'm out at my mam's until like 7/8 o'clock, I'm fine. I don't, like I'll just have a couple."

(Bev. Wave 3)

"erm, actually, I'm proud of the fact ... That I can go, something like 3 weeks without a drink now. I'm not getting the rattles that I always had. I think my mind is

²⁸ See section 7.3.3 for a more detailed analysis of Joseph's positive trajectory, including the impact of his ESA sanction.

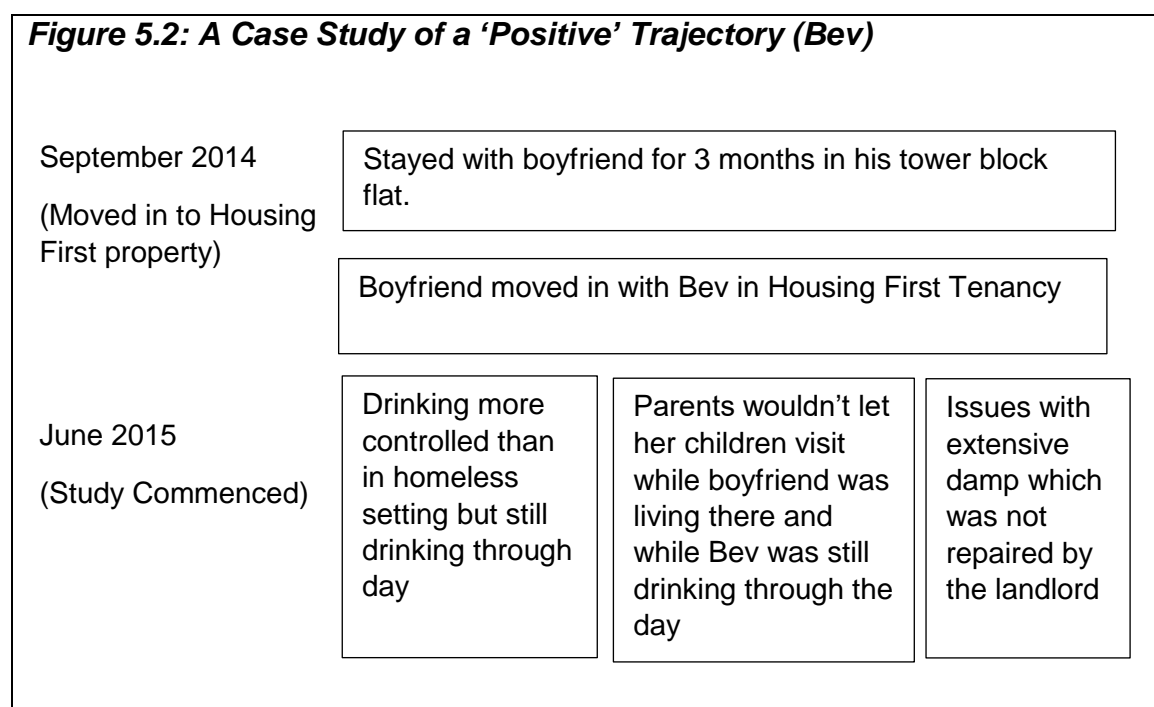
thinking, if I run short of the milk or the marg or whatever, or bread, I'd rather buy them than the drink. So I'm proud of my own self on that one."

(Joseph. Wave 3)

Johnny engaged in volunteering while in a homeless hostel, and his drug use was already controlled to some extent. Nevertheless, each gained a greater sense of control of their situation and substance use. Subsequently, they were able to develop links with their children, separate from associates and engage in a college course and begin searching for work.

Lisa had the significant motivator of a new born child and had successfully negotiated a transition from heroin to methadone, then a reduction in her methadone intake, in order to be able to care for the child. In the early waves of the study, she did retain some associate relationships while pregnant but still managed to abstain from any drug use, a findings which contradicts the often negative role of these relationships in achieving positive outcomes (Dingle et al. 2015; Nelson et al. 2015). By the third wave, she had separated from these associates, not seeing them for over 6 months. Figure 5.2 highlights Bev's trajectory as an example of a positive trajectory in this study.

Figure 5.2: A Case Study of a 'Positive' Trajectory (Bev)



<p>March 2016 (Moved Flat)</p>	<p>Service negotiated a move to area closer to parents. Mainly due to damp issues.</p>
	<p>Bev broke up with her boyfriend</p>
	<p>Parents agreed her children could visit</p>
<p>September 2016 (Study Ended)</p>	<p>Bev's children spent much of the summer holidays at her flat, staying overnight regularly.</p>
	<p>Bev reduced her alcohol use further. She also began receiving specialist recovery support for her alcohol use.</p>

Bev's began by feeling apprehensive, she did not move into her flat for 3 weeks, instead staying at her younger boyfriends flat. She eventually grew tired of this lifestyle, describing it as a 'youth club' and move back to her own house. Bev's had widespread issues with damp which the landlord did not seek to repair. Bev did not see her neighbourhood at her first property as a positive place to live.

Bev's children live with and are under the care of her parents. She lost direct custody due to her alcohol use and abusive ex partners. For these reasons, her parents would not allow Bev's children to visit her flat while her current boyfriend was living there, and while she continued to drink through the day. Bev eventually negotiated a move to another private property, through the HF service in March 2016. Bev's second property was located close to her parents' house and the move provided a catalyst for Bev to end her relationship with her boyfriend, both of which enabled increased access to her children²⁹.

Bev continues to use alcohol, but has reduced her intake further, only usually drinks in the evenings and is accessing specialist recovery support. She sees her daughters most days now, with them regularly staying overnight during the summer holidays.

The importance of Bev ending her relationship is substantial, throughout her life she has been in abusive relationships, which have contributed to anorexia, speed

²⁹ see Appendix B.3.2 for a situational analysis of Bev's decision to end her relationship with her partner

addictions and alcoholism. Ending the relationship enabled increased access to a positive form of companionship through her immediate family.

Her current flat has some cosmetic issues with repairs but does not have damp and Bev is generally positive about her neighbourhood. Overall, Bev's trajectory is positive.

Fluctuating Trajectory

When data collection ended, six participants were experiencing fluctuating trajectories with some periods in which they were progressing towards measured outcomes. However, relapse in substance misuse or offending behaviours was also common, setting participants back and creating new barriers to ongoing progression. It was not possible to identify either a trend towards a positive or a static trajectory in the experiences of these participants. Instead, there were clear periods of recovery and desistance and progression towards positive outcomes, intersected by periods of relapse. These periods of relapse were commonly instigated by either a stressful event that brought up past trauma, temptation by former associates or most often a combination of both. For example, Carl demonstrated considerable attempts at 'home making', paid his bills and rent on time and desisted from heroin and synthetic cannabinoid use through wave 1 and wave 2, using only his methadone script, alcohol and Valium. However, removing 'painkiller' type drugs led to the re-emergence of previous trauma, and a worsening of his mental health at wave 2:

"I think me mental health's gannin a bit worse like, since I've quite the legal high I'm starting to hallucinate again.

Interviewer: Right, so the legal high was stopping you from doing that was it? Well it wasn't really stopping is it was just putting is to sleep, I was like comatose aye."

"... I'm not saying I'm seeing him [childhood friend who committed suicide] every day. I'm up and down. One day I'll wake up and I'll feel cush, one day I'll wake up and I'll feel like ripping someone's heed off.

(Carl. Wave 2)

Even through these challenges with his mental health, Carl managed to continue a generally positive trajectory. Despite having associates coming to his flat to drink, take Valium and socialise, one of which Carl considered a close friend. However, this socialising led to an incident of extreme violence in which Carl's close friend was murdered by an associate, having a traumatic impact on Carl and leading to a worsening of his mental health, and an increase in his alcohol use, as well as a short return to heroin use and an arrest for shoplifting.

“Nar, I was starting to cut down ... but I've started hitting the black cans again and the sweaty black cider. I just used to drink these alcopops when he was about, cos he used to sit and drink it with is.

And I've been hitting the drink a hell of a lot just to try and blank it out. But it's still there the next day when I wake up.”

(Carl. Wave 3)

Other participants who experienced a fluctuating trajectory faced similarly traumatic incidents. For example, Joel was arrested and imprisoned after a mental health crisis³⁰ and Lyla was forced to abandon her property after being accused of 'grassing' by local gangsters. Gary and Linda on the other hand experienced relapses without any clear, singular catalysing event. Instead, the general stress of having a tenancy led to periods of increased substance use, damage to flat's and confrontation. As Gary's case manager notes:

“He's always finding problems of why he can't be there, but no one's actually said you're being evicted. It's just in his head, his paranoia. He's convinced that they want to get him out ... As long as he pays his rent, but he sees it as a personal attack on him.”

(Case Manager)

³⁰ See Appendix B.3.1 for a situational analysis of this event, and the consequences for Joel's trajectory

For Linda, the reasons were less related to issues of control and more related to general monotony:

“I got bored of it [the flat] then I just started drinking and smashing it up. See when we first moved in, I was alright for about 2 – 3 month then I just started drinking and smashing the place up. That’s about the fifth coffee table, that’s about the third coffee stand.”

(Linda. Wave 2)

Once she had used up her own money, Linda reverted to going into the city centre where she knew certain homeless associates would buy her alcohol.

“I gan see some people I know and they get is a bottle... I wouldn’t dare gan tapping man!”

(Linda. Wave 2)

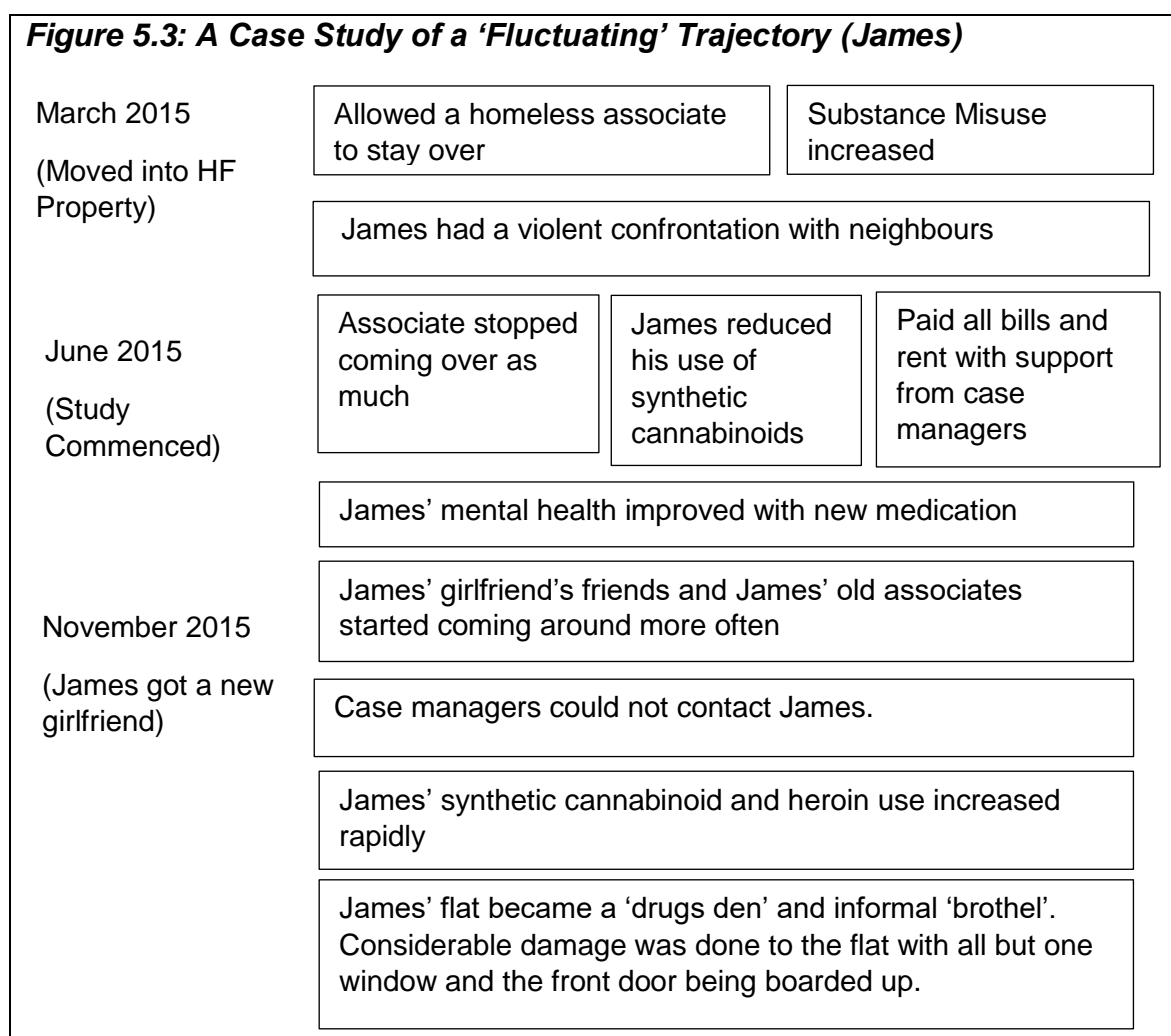
The causes of relapse varied; either being caused by associates, neighbours, confrontation with police or an accumulation of the stress and monotony of maintaining a tenancy. However, the result was the same for most, reverting to familiar to behavioural preferences; namely the participants’ preferred form of substance use. Associates with substance misuse issues and emotional stressors are both understood as common causes of relapse in recovery (see section 3.5.3) and the presence of formerly homeless associates was also noted as a key hindrance in the trajectories of participants in the Canadian ‘Chez Soi’ evaluation (Nelson et al., 2015; Volk et al. 2015) (see section 2.6.2 – 2.6.3).

Engagement in substance misuse as a means of coping was commonly followed by engagement in violence, offending, or damage to the tenancy. As Wikström (2014) notes temptation, in this case to engage in substance misuse is a key motivator, which depends on the confluence of two key factors; desire and opportunity (see section 3.5.1). Firstly, desire, which commonly emerged as participants’ sought an action alternative to relieve the emotional stressor they were facing. Secondly, opportunity, which emerged in the form of associates who participants either came across in their particular location, or had simply continued to maintain links with.

In turn, intoxication through increased substance use reduces an individual's capacity for self-control (Wikström & Trieber, 2007). Self-control involves the capacity to suppress the desire to choose an action alternative due to perceived negative consequences. Becoming intoxicated skews the perception of those consequences, making it easier to engage in that behaviour. Carl puts it very simply when asked why he shoplifted:

"Interviewer: So why were you shoplifting?
 (laughs) Can I tell you the truth, I took a strip of Valium."
 (Carl. Wave 2)

Figure 5.3 now highlights James' trajectory as an example of a fluctuating trajectory in this study.



James' experience represents an example of a flat becoming a resource for associates. The ASB and range of issues which followed prevented James to move forward towards his own personal outcome priorities.

However, James' time in prison and eviction acted as another 'fateful moment', offering a turning point for James. The HF service found him another flat in a different area. What followed was a period of abstinence from illicit substance use and a subjectively positive relationship with a new girlfriend.

"I've just stopped seeing anybody. I spend all me time with her. She was like bad on the drugs when I first met her and were both stable on scripts now"

(James. Wave 3)

However, this period of positive trajectory seems to be tenuous as highlighted by the final update from his case manager. As his continued recovery relied on his new girlfriend's parallel recovery, there was a risk that it was tenuous, with relapse for one leading to relapse for the other.

"But say when she's woke up a bit like, you know when its getting all too much for we, I can encourage her. Then if like feeling like she is, she can do it for me. So we've just been helping each other out really."

(James. Wave 3)

Static Trajectory

Four participants were experiencing little or no progression towards personal priority outcomes. They were commonly engaging in behaviours and routines that were largely representative of their time spent in a homeless setting. Interviews and observation of these participants demonstrated no clear evidence of a positive trajectory, or movement towards any outcomes associated with positive long-term change. Only Arnie achieved his priority outcome of remaining close to his "homeless family". However, Arnie's perspective on this homeless family had shifted by the final wave of interviews:

“Interviewer: So you’ve got all your homeless pals, you wouldn’t say you completely trust any of them?

Nah, cos they’re pals but they’re what do you call that word, what’s that other word for friends?

Interviewer: They’re associates?

Aye, that word.

Interviewer: They’re people who you hang round with but at the same time you don’t have that deeper emotional connection?

P: Nar, would I fuck!”

(Arnie. Wave 3)

Jimmy also offered a similar perspective on ‘friendships’ in a homeless setting:

“The most important thing I found being on the street, is deceitfulness, the friends you call your friends, they steal your bags, they steal your hotpots and your pot noodles,”

(Jimmy. Wave 1)

Arnie’s perspective had shifted after around 16 months of allowing associates into his flat, with various issues arising and little reciprocity received from them. This shift in perspective may indicate a wider shift in Arnie’s trajectory, but as this was the final interview with Arnie, there was no data to support this hypothesis.

Jimmy and Lenny both experienced similar issues with associates. Both sought companionship but ended up feeling that they were being exploited both for the use of their flats and financially. As Jimmy succinctly put it:

“I get drunk, fall asleep and they take”

(Jimmy. Wave 1)

As such, participants continued to engage in the same behaviours, alongside the same associates but in a different living situation. They were “*rough sleeping in a flat*” as one case manager put it. Liam was housed in a flat far outside of the city centre and had

no issues with associates, but he did continue to engage in the same in alcohol use throughout every day.

All participants with a 'static trajectory' continued to engage in substance misuse to the same level with no or very limited reductions. For all, their only substance misuse issue was with alcohol. In turn, all participants continued to engage in street culture activities and offending behaviours representative of their personal histories. For Arnie and Lenny this meant begging, street drinking and rough sleeping. For Jimmy and Liam this meant engaging in anti- social behaviour while drunk in the shopping areas close to their houses. Around a month after the 'Wave 2' interviews Lenny was found to have died in his flat, reasons were unclear but service managers attributed it to chronic health issues related to long term rough sleeping and alcohol use.

At this point, it is important to note that a static trajectory is not necessarily 'worse' than a fluctuating trajectory. Those with fluctuating trajectories often faced greater harms, more severe substance misuse and more severe relapses in mental health issues. Indeed, all participants with a 'static' trajectory were able to carry out most tenancy sustainment tasks such as paying the majority of bills and rent. However, these tasks were only completed with considerable support and encouragement from case managers, particularly in spotting arrears early enough to create payment plans:

"I'm up to date with paying my gas and electricity, and I don't worry about paying these things, because if I go back on the streets, I'll just shut the door, put all this back into storage"

(Jimmy. Wave 1)

"I had to come to terms with it, either get prosecuted from not having a tele license, I sit in the dark, wey that's their problem, management [in hostels], it's not my problem."

(Liam. Wave 1)

What differentiated those with a static trajectory was a lack of sustained desire for, or evidence of change. As shown in table 5.1 in section 5.2.1, the priorities outcomes of these participants were less ambitious than other participants and their desire to reach these priorities, as well as other outcomes was also less evident. One reason for this may be that each of these individuals was a man in their 50's with alcohol as their primary substance misuse issue, a long history of rough sleeping and chronic health issues, each of which are considered further in section 6.3. Figure 5.4 now offers a more detailed description of Arnie's trajectory as an example of a 'static' trajectory.

Figure 5.4: A Case Study of a 'Static' Trajectory (Arnie)

June 2015 (Study Commenced)	Arnie underwent a 10 day hospital detox for alcohol.
	Began drinking again after around a week
September (2015) Arnie began his Housing First tenancy	Arnie moved into a Housing First tenancy closely located to direct access homeless hostel.
	With support from the Housing First service, Arnie topped up his gas and electric card meter.
January (2016)	Arnie collapsed in the street and had a period of 'alcohol induced fits'. He was taken to hospital and stayed in for 3 weeks over Christmas.
	Associates continued to stay in his tenancy while he was gone.
July 2016 (Third Wave of Interviews)	Left hospital and began drinking again. Used the IV pads to generate sympathy when 'tapping' (begging).
	Arnie acknowledged that he had 'lost control' of who enters his Housing First tenancy.
	Arnie was taken into hospital again after collapsing
	Arnie can't get his boiler to function after being shown twice. He rarely tops up his gas and electric meter

	<p>Arnie expresses no desire to change his behaviours:</p> <p><i>Well aye, course I still love me tappin.</i></p> <p><i>But I think, I divn't take drugs or nowt like that, but, I'm an alcoholic. But me being an alcoholic, I think I'm a little bit stronger than these people who take this legal fucking high stuff.</i></p>
<p>September 2016 Study Ended</p>	<p>Arnie's support worker worries that he is being financially exploited by a female homeless associate. He admits to giving her his bank account details.</p>
	<p>Arnie's expresses that associates are preventing him from benefiting from his flat but still have 6 people staying there.</p>

Arnie did not express any desire to stop associating in street culture activities or with homeless associates. In fact, he expressly asked for a flat close to homeless services and the city centre. He did express a desire to maintain the sobriety he had gained from a hospital detox.

Arnie's capacity to do so has arguably been hindered by his ongoing relationship with associates. He has essentially continued the same lifestyle as when he rough slept, but in a flat. Much of Arnie's adult life has been spent in institutions or in homeless situations. In addition his long term partner died 6 years ago³¹. The combination of these factors may partially explain his desire for social connections rooted among homeless associates, as well as his ongoing desire to engage in substance use and street culture activities such as 'tapping'.

Arnie demonstrated lower social trust and a lessened sense of ontological security in wave 3 indicating that he may attempt to regain independent control over his tenancy. Qualitative evidence suggests this is the cumulative effect of associates frequenting his flat, and his limited knowledge on how to maintain it appropriately.

³¹ See section 6.4 for further discussion of the role of life histories in determining trajectories.

5.4: 'Success' Across Individual Outcome Domains

This study focused on inherently subjective and individualised notions of choice, control and success, exploring change within participants' situations before comparing across cases. Consequently, analysis and findings primarily focus on the individual experiences and trajectories of participants. However, as a means of situating these findings in the wider HF literature it is also useful to give a brief overview of progress in domains, as much literature focuses on this type of analysis and output (see section 2.6.3).

Section 5.4.1 and 5.4.2 highlight findings in relation to housing retention and the development of a 'home' with reference to the points raised in section 2.7.1. Sections 5.4.3 to 5.4.8 highlight findings in other outcome domains which housing is designed to provide the foundation for achieving.

5.4.1: Housing Retention and Stability

There are a number of considerations when measuring housing retention for participants in HF. Primary concerns are how long to measure for? *and* what constitutes a failure to retain?

The first question presents less of a challenge for this study. The two key options were to either measure for the duration of the study *or* as some individuals were already in their tenancies prior to the study commencing, to measure for the duration of an individual's tenancy. The decision was taken to measure retention for the study duration. For those who entered their property after the study commenced, retention was measured from the point at which they began their tenancy. Doing so allowed a deeper analysis of the role of retention as an outcome measure. Outside the study duration, there was little data available to identify how 'stable' and 'at home' participants felt in their property. As this study is primarily concerned with what happens after participants are first housed, this data was essential to make a reasonable assessment on 'stability' and 'home building'.

The second consideration is concerned with the point at which a participant is no longer deemed to be retaining their property. Evictions clearly constitute a failure to retain but the causes of eviction may not necessarily reflect a failure on the part of the participant. Abandonments arguably reflect a failure to retain but may be perfectly reasonable if a threat to personal safety emerges. Moving properties is done for a range of reasons, and is arguably less likely to constitute any failure to retain than evictions or abandonments. A final consideration was whether to include participants who entered the HF service but never actually ended up being housed.

US studies associated with the original Pathways implementations measured “residential stability” by retrospectively tracking the number of days which participants were “stably housed”, using residential follow back calendars (Padgett et al., 2006; Tsemberis et al., 2004). This method was not employed in this study, as such, direct comparison with these implementations would not be appropriate. However, the HF Europe evaluation did provide a useful point of comparison. Busch-Geertsema (2013) noted variations in how housing retention rates were measured across different evaluations. In the summative report, Busch-Geertsema (2013: 54) commented on the definition of retention which was employed to collate these rates:

“In general we have measured housing retention by the proportion of people who have been assigned housing by the HF project and have managed to sustain a tenancy (or to move to another tenancy) with the support of the project. If people have left the local programme in order to live in another apartment this was generally seen as a positive case of housing retention. If people have died during their stay in the HFE project we have excluded such cases from the calculation of housing retention.”

The report also made comment on periods in which participants were imprisoned, a consideration for this study. Busch-Geertsema removed two participants who were imprisoned in the Glasgow implementation and lost their properties because they could no longer pay their rent, but stayed in close contact with the HF project. Two participants

were imprisoned in this study, but under different circumstances. Both were imprisoned after allegedly engaging in illegal activities in their flat. In this study, only one participant lost their property as a direct result of being imprisoned, Joel. Joel was not rehoused by the service after release from prison and did not receive ongoing support from the service³². Therefore, both participants who were imprisoned have been included in housing retention rates. As a result of these numerous considerations, a range of housing retention rates are offered, as demonstrated in table 5.5.

<i>Table 5.5: Housing Retention Rates for Study Participants</i>		
<u>Housing Retention Rate (excl. abandonments and 'never moved in's')</u>	<u>Housing Retention Rate (incl. abandonments)</u>	<u>Housing Retention Rate (incl. abandonments & 'never moved in's')</u>
87.5%	75%	66.7%

As highlighted in the above table, housing retention rates focusing solely on evictions are representative of high retention rates in other studies (e.g. Aubry et al., 2015; Bernad et al., 2016). However, rates are less favourable, when abandonments are included, and when participants who joined the service but never moved into a tenancy are included.

5.4.2: 'Home Building' and Housing as Foundation

Variations in housing retention rates (according to the definition employed) begin to demonstrate some of the nuances behind perceptions of stability implied by housing retention (Gieryn, 2002; Clapham, 2011). As will be demonstrated in subsequent sections, focusing primarily on housing retention rates may hide great deal of nuance in how successful the service is in enabling the stability required to pursue other outcomes, as

³² See Appendix B.3.1 for a more detailed analysis of the event which led to Joel's imprisonment.

suggested by other studies (Martins et al., 2016; Ornelas et al., 2014; Yanos et al., 2004). This represents a key strength of this more detailed, qualitative study, which unpicks the lived experiences that lie behind favourable housing retention rates in large scale, quantitatively orientated HF studies outlined in Chapter 2.

It is relevant to note that participants' housing situations did not generally worsen as a result of entering a HF tenancy. For all who entered a property, their homelessness (at least in simplistic terms of not being in a hostel or rough sleeping) had been solved.

One potential caveat here is Lenny. Lenny died while in his HF tenancy. However, the reasons for which can be more readily related to a lifetime of disadvantage mediated through chronic substance misuse, homelessness and resulting health conditions.

There was also considerable variation in the extent to which participants' invested in their flat, in terms of sourcing items and general maintenance. One case manager summarised the perspectives of many by noting:

"I have met other clients who are working with other members of staff here, who getting their flat has changed their behaviour. Because they've gone in, cleaned it up, and they keep it clean. They're drinking has gone right down ... But moving into that flat has changed them, they're proud of their home, they're getting access to perhaps children, their kids are coming round. But I must say a lot of people move into their flats and just rough sleep in them."

(Case Manager)

Another case manager elaborated further on the phenomena of 'rough sleeping in a flat':

"Everything he needed is in the arc and he wouldn't travel outside that arc. He's sitting on the sofa, or in Jimmy's case on his bed. Booze here, fags here, bucket here. You just look at his flat and you think, you don't actually go in any of the other rooms do ya, all you do is just sit there, and that's just like a rough sleeper."

(Case Manager)

To highlight these variations further, figures 5.5 to 5.8 show the living rooms of four different participants. Considerable differences can be seen between Joseph and Carl's living rooms, which are generally tidy, clean and set up as a living room. In contrast, Jimmy's living room is just that, a room in which Jimmy does all of his living. Arnie's living room has no decoration and as highlighted by the duvet in the corner is used as a sleeping area for homeless associates on most nights.

Figure 5.5: Joseph's Living Room (Positive Trajectory)



Figure 5.6: Jimmy's Living Room (Static Trajectory)



Figure 5.7: Carl's Living Room (Fluctuating Trajectory)

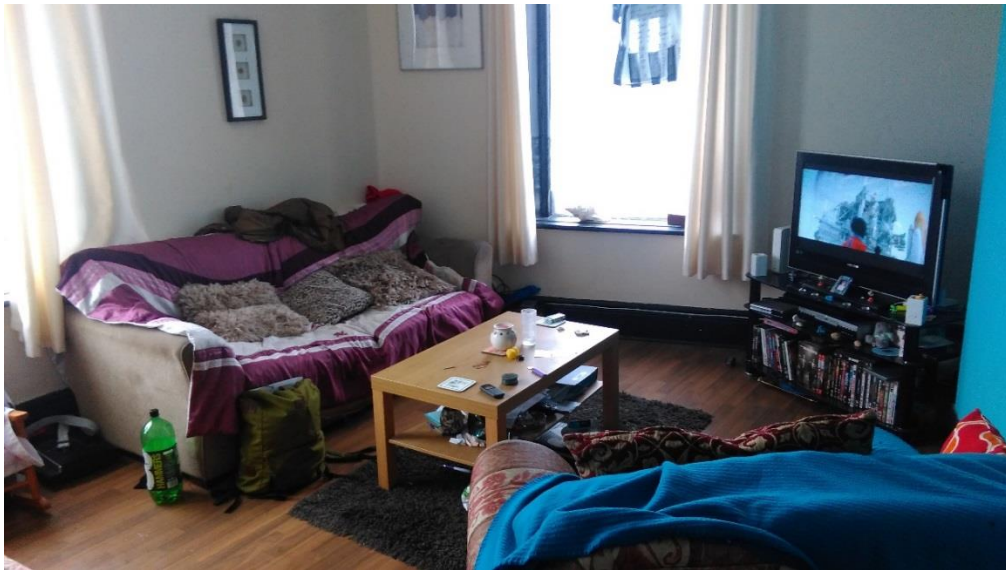


Figure 5.8: Arnie's Living Room (Static Trajectory)



What constitutes 'a home' is highly subjective and this study is not suggesting that any flat is inherently 'better' than any other. Further, it would not be fair or accurate to attribute these variations solely to a lack of personal motivation. Due to the limited availability of properties (see section 7.2.1) there were often existing issues with the quality of some accommodation:

“At least they’ve got a base, even if it’s a bit of a shit base. Some of the flats weren’t the best but at least we checked them out before we moved people into them, and we had to turn down a couple.”

(Service Manager)

“She had a lot of repairs to be done, I was constantly on the phone when she first moved in. She had damp, I couldn’t stand the smell, you know when you go in, the smell, its foisty. So it was frustrating for us because were constantly on the phone, but it was also frustrating for the clients because they’ve got to live in it. So the landlords, I think some of the landlords we have, don’t seem to give a toss.”

(Case Manager)

Although, structural barriers associated to accessing market based housing hindered the service’s capacity to source high quality properties. One case manager also noted that some participants could not reasonably afford to prioritise buying decorative items, and an additional budget would help with this:

“But what I would really like is a pot of money to be able to put our own touches on a flat, to be able to make it a home... Put a few pictures up, put a mirror up, put a lamp in the corner. They don’t have to cost much, you can get them cheap as chips. But just to make it feel like a home.”

(Case Manager)

One participant suggested that the probationary tenancy removed his motivation to decorate:

“You see the reason I haven’t like decorated it, is because I’m on like a 6 month short hold tenancy, and once that’s passed”

(James. Wave 1)

As identified in section 2.7.1, the ‘meaning of home’ is highly subjective. However, there was an observable relationship between the amount of effort which had gone into ‘home building’ (buying items, taking pride through cleaning and tidying etc.), the

ownership participants' felt over their property, and their outcome trajectories. As identified by Clapham (2011) housing has the potential to act as a foundation for the pursuit of subjectively meaningful goals. However, this foundation is dependent on housing offering stability, and ontological security.

5.4.3: Housing First, What After?

The variability in housing stability and security amongst participants was also reflected in mental health, offending, 'street culture', 'community integration' and 'meaningful activities' outcomes. Any outcomes apparent in these domains were unevenly distributed across participants, being experienced in a sustained way by only a few.

Those participants with a positive trajectory did seem to be able to utilise the foundation provided by the HF service to reach outcomes related to subjective improvements in mental health, developing ties with family, developing social ties, and engaging in meaningful activities. In turn, it seemed likely that these trends would continue due to the consistently positive trajectory these participants experienced. The following sections briefly cover outcomes in each of these domains.

5.4.4: Substance Misuse

Substance misuse outcomes were the least forthcoming for any participants. There was some evidence among those with a positive trajectory, but their issues were less severe in terms of both the type of drug and number of drugs used.

In line with other HF studies (Kertesz et al., 2009) and substance misuse recovery literature (Laudet & White, 2010), only two participants achieved abstinence from substance misuse issues (see section 2.7.2). Johnny had already generally achieved abstinence from his only self-reported addiction (heroin), instead transitioning to methadone. Lisa also transitioned to only using methadone with the considerable motivator of being able to keep and raise her son, as well as considerable support from social workers, drug and alcohol support workers, HF case managers, the local 'Sure

Start' centre and her family. Of course, Lisa's achievements are not to be underestimated but it is important to recognise that neither her, nor Johnny's substance misuse issues were as severe as some other participants³³.

A number of participants noted periods of greater control over substance misuse, but these were rarely maintained throughout the study period. Nevertheless, they do contrast sharply with retrospective accounts of time spent homeless in which participants' consistently noted very little control over their substance use.

Those with chronic alcohol dependencies (with the exception of Joseph) continued to engage in alcohol use at similar levels, but did demonstrate some periods in which the potency was reduced. For example, Jimmy highlights this period while talking about a subsequent period of relapse:

"I felt like I was going back to the old Jimmy when I started pouring out whiskey and getting back to, I was going back to the old life."

(Jimmy. Wave 2)

For most participants, substance misuse continued to affect them in a similar way. Some reported fluctuating between periods in which use was more controlled, and binge periods of extremely high use.

Those with poly substance issues continued to engage in poly use, but some did note successes in moving off specific substances deemed as particularly harmful, such as synthetic cannabinoids:

"“How did you get off it?” I says you know what, bad rattle, really bad rattle and like craziness in me mind“

(Lyla. Wave 2)

Substance misuse outcomes are generally less likely to be achieved in HF (Kertesz et al. 2009; Woodhall-Melnik & Dunn, 2015). In turn, substance misuse recovery

³³ See Appendix B.2.1 for a more detailed analysis of participants' substance misuse issues

is consistently considered to be a long process, fraught with relapse (Laudet & White, 2008, 2010; Padgett et al., 2016; Terry & Cardwell, 2015; White, 2007). As such, limited progress within the 16 months of this study is to be expected, and not necessarily representative of any failing of the service itself. In fact, achieving periods of greater control, overcoming the harmful effects of a single drug, and maintaining a methadone script all constitute considerable successes.

5.4.5: Mental Health and Wellbeing

Considerable differences were apparent in the mental health issues faced by participants making comparison difficult. Mental health outcomes were also difficult to establish as many participants did not have specific diagnoses, and self-reported a range of mental health issues. Consequently, the study concentrated on subjective changes in mental health, and access to mental health treatment, as well as employing measures of happiness, and emotional wellbeing, all of which offer some indication of the general mental health of an individual at the time of questioning. Each of these approaches is promoted within the HF Europe guide (Pleace, 2016), although Pleace does note assessments of mental health changes would ideally involve mental health experts, which this study does not.

Only Arnie and Lisa reported that an improvement in mental health which was sustained in their responses at each wave of data collection, albeit under very different circumstances and not without some periods of increased stress. Two participants (Gary and Lenny) experienced reported declines in mental health at each wave, for each the main reasons were stressors caused by associates and romantic relationships as well as general dissatisfaction and a lack of security felt in their tenancy. However, the majority of participants (n= 9) reported fluctuating mental health, often in line with wider changes in their trajectories. A trend towards fluctuating mental health is in line with mental health outcomes in HF more generally (Nelson et al., 2015).

In general, participants experienced limited access to mental health treatment. Original implementations of HF demonstrated decreases in psychiatric hospitalisations as positive outcomes, as the service provided community based treatment instead (Padgett et al. 2006). In contrast, limited access to mental health treatment and support is considered a negative outcome in this study, as the service in Newcastle did not directly provide this support.

Only two participants (Carl and Lisa) reported that they accessed treatment throughout the duration of the study, and for both this mental health support was provided by drug and alcohol treatment workers who had also been trained as community practitioner nurses. Two other participants (Joel and James) were accessing mental health support and receiving prescribed medication, but this stopped when each entered prison. Johnny was not initially accessing treatment but after a bout of depression brought on by family issues he was able to access community support through his GP. Importantly, all of these participants' noted that when they were accessing mental health support, they were satisfied with the support they were receiving, suggesting this was helpful to them. The remaining participants (n=8) were not accessing mental health treatment at any point in the study. The reasons varied but were either due to the exclusion criteria of the mental health service (lone working concerns or dual diagnosis), or self-exclusion by the participant themselves³⁴. Each of these issues may be overcome to some extent through an ACT style approach, such as that offering in the original implementation (Pleace, 2011; Woodhall-Melnik & Dunn, 2015). This multi-disciplinary approach allows the service to operate within the principles of HF, limiting the effects of dual diagnosis, and 'brings the service' to clients, removing barriers to self-exclusion³⁵.

³⁴ Each of these are discussed further in section 7.2.2 and in reference to each 'type' of participant in section 7.3.1 – 7.3.4.

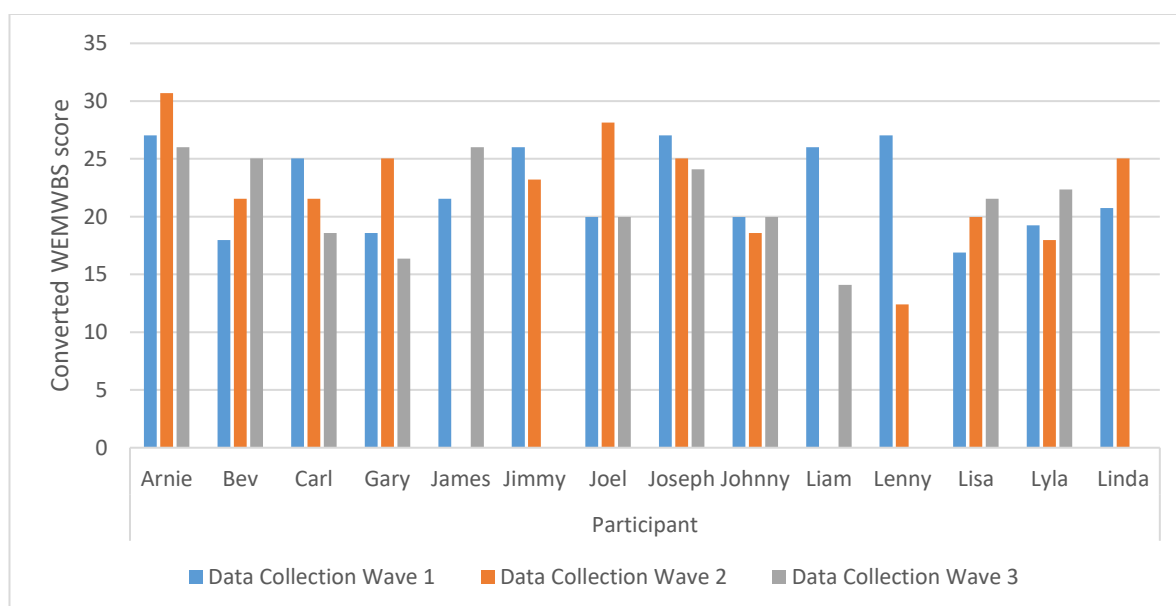
³⁵ See section 2.5 for an outline of the ACT approach used across larger scale implementations of HF.

In addition to these mental health outcomes, the short version of the Warwick Edinburgh Mental Wellbeing Scale was employed. The scale which focuses specifically on mental wellbeing rather than broader conceptualisations of wellbeing (NEF, 2013).

Mental Wellbeing

Participants' sense of personal mental wellbeing was established through qualitative questioning and the SWEMWBS measure (Tennant et al., 2007). The measure is the shorter (S) version of Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). Scores were transferred to metric WEMWBS scores using the guide and conversion chart provided by the originators of the measure. The measure was implemented at each wave of interviews. Missing 'columns' occur where participants were unavailable or did not complete the measure for any reason.

Figure 5.9: Participants' Converted SWEMWBS scores



Based on scores, only Lisa experienced increases in mental wellbeing in each between each wave of interviews. Linda and James experienced increases but data was only available on two waves. In turn, updates from support workers suggest that during

periods in which data was missing, these participants were experiencing periods of relapse and so were likely, albeit not guaranteed, to have lower scores.

Five participants (Carl, Jimmy, Joseph, Liam, Lenny) experienced decreasing trends in mental wellbeing over the study period, although data was not available at wave 2 for Liam. The remaining five participants (Arnie, Bev, Gary, Joel, Lyla) experienced a fluctuating trend in their mental wellbeing. However, amongst these fluctuations two experienced a net (wave 1 – 3) decrease in mental wellbeing over the study period (Arnie, Gary), two experienced a net increase during the study period (Bev, Lyla), and one's (Joel) mental wellbeing score remained the same.

Mental wellbeing scores were therefore relatively closely aligned to subjective mental health assessments with the notable exception of Arnie who reported a sustained improvement in mental health but a fluctuating trend in mental wellbeing, amidst a net decrease for the study duration.

There were no consistent trends which related access to mental health treatment to either improvements or declines in mental wellbeing. This is perhaps unsurprising since mental wellbeing encompasses a wider assessment of an individual's feelings about their situation, as a result, accessing treatment is only part of what enables improved mental wellbeing.

5.4.6: 'Street Culture' and Offending

Considerable overlap existed between those participants who engaged in offending behaviours and those who engaged in 'street culture' activities through the study period.

It is first important to note that the offending histories of participants varied greatly³⁶. In this section, it is relevant to note that some participants had long histories of offending and street culture activities encompassing a wide range of offences (Carl,

³⁶ Variations in participants offending histories are discussed in Appendix B.2.1

James, Joel, Arnie, Lyla, Johnny). Although, Johnny is an anomaly, having only limited engagement in street culture activities and having not engaged in any offending for around 10 years prior to entering HF. Other participants had very limited experience of any offending with only warnings or fines for being 'drunk and disorderly' (Bev, Lisa, Gary). The remaining participants had histories in which offending was common but was entirely based around anti-social behaviour and 'drunk and disorderly' offences, almost exclusively from time spent in homeless situations (Jimmy, Joseph, Liam, Lenny, Linda).

During the study period, a small majority of participants' (n=8) did face criminal charges for offences committed during their time in their HF tenancy. Offences were most often associated with anti-social behaviour or breaching public space protection orders (Arnie, Carl, Jimmy, Lyla). However, two participants did also engage in single incidents of shoplifting (Joseph, Carl) and four participants were charged with violent offences (Gary, Jimmy, Joel, Joseph), each under different circumstances. James was charged with running a brothel, but was found *not guilty* of this offence, only after spending two months on remand. The remaining six participants (Bev, Johnny, Liam, Lenny, Lisa, Linda) did not face any charges during the study period.

In total, eight participants continued to engage in street drinking with varying regularity. Four participants regularly engaged in such activities through the study period (Arnie, Carl, Jimmy, Lenny), two participants irregularly engaged in street drinking (James, Lyla) and two irregularly engaged in street drinking only during specific periods of 2 – 3 months (Linda, Joel).

There was considerable overlap between those participants who engaged in street drinking and those who engaged in begging activities. Four participants (Arnie, Carl, Lenny, Lyla) continued to engage in regular begging, with each positioning this activity as an essential source of additional income. In addition, James and Joel engaged in irregular begging. However, the majority of participants (n=8) did not engage in any begging, although only three of these participants reported that they had previously engaged in

such behaviours. Some participants rough slept, commonly after periods of begging and street drinking ran late into the night, lacking the motivation to walk back to their HF tenancy five participants rough slept with associates in the city centre. However, such occasions were singular for most (n=3), only Lenny and Arnie rough slept more regularly.

Evidence from the Canadian Chez Soi demonstration project (Volk et al., 2015) suggests that those participants with the strongest ties to 'street culture' and homeless associates face the greatest challenges in achieving positive outcomes in HF. The evidence here supports these findings, suggesting that those participants with the most extensive histories of offending and street culture activities were the most likely to continue to engage in these offences. An explanation of why these participants continue to engage in these behaviours is taken up in section 6.3 where certain 'street culture' activities are understood as capabilities on which participants can draw to make money³⁷. Those with greater experience of using these capabilities are more likely to continue to employ them, even though they conflict with wider social and legal norms.

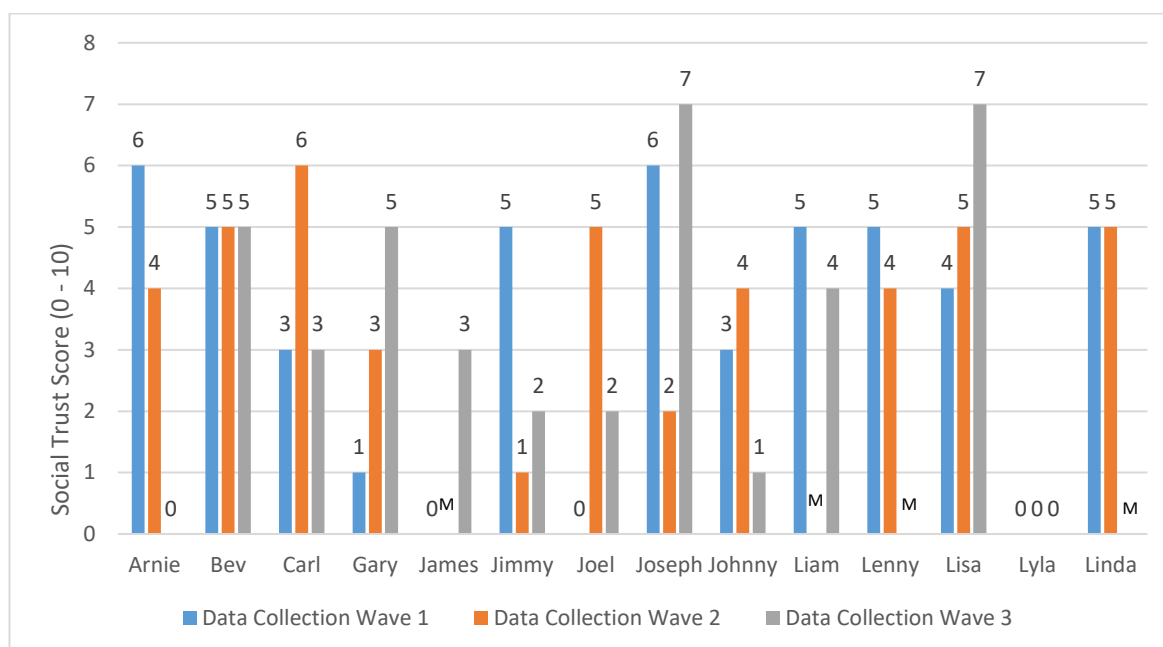
5.4.7: Community Integration

There have been some favourable outcomes around community integration in the HF literature (Martins et al., 2016; Ornelas et al., 2014; Yanos et al., 2004). However, fundamental questions remain about the extent to which HF can enable wider social inclusion amidst a life time of disadvantage and exclusion, as well as considerable structural challenges (Quilgars & Pleace, 2016). Community Integration was measured in this study through a single item 'social trust' measure. The question was taken from NEF (2013) and was employed as a means of gathering participants' overall sense of social trust. The question was '*generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?*', responses were on a scale from 0 – 10 with 0 referring to 'can't be too careful' and 10 referring to 'most people

³⁷ Further discussion of the incidence of 'street culture activities' can also be found in Appendix B.2.1

can be trusted'. Data labels have been added to figure 5.10 in order to differentiate between missing data (M) and instances in which participants' responses were 0.

Figure 5.10: Participants' 'Social Trust' Scores across each wave



The first observation that can be made is that levels of social trust varied considerably between participants, and with the exceptions of Lyla, Linda and Bev were also variable across waves. For participants for whom data was available at all three waves four experienced a net increase in their sense of social trust over their time in HF (Gary, Joel, Joseph, Lisa), three experienced a decrease (Arnie, Jimmy, Johnny) and scores remained static for the remaining three (Bev, Carl, Lyla). However, differences emerged in the trends in participants' scores across the three waves. For instance, four of these participants' experienced quite considerable fluctuations in their sense of social trust (Carl, Joel, Joseph, Johnny) which may suggest that situational factors had encouraged them to give higher or lower scores at different stages.

The study also employed qualitative questioning which was focused more specifically on participants' local community and neighbourhood. Other studies focused on community integration have also employed qualitative methods (Yanos et al., 2004). The

dominant theme which emerged in participants' responses was to focus on interactions with neighbours in the immediate vicinity of their tenancy. These findings give further support to the importance of 'local social networks' (section 3.5.3).

Five participants consistently reported good relationships with neighbours and general satisfaction with their local community (Carl, Gary, Joseph, Johnny, Lisa). These participants regularly went out into their community engaging in activities like shopping, and using community resources such as community centres and libraries. Gary did briefly move into a tenancy in another area and moved due to concerns about crime in the neighbourhood after only one week. In turn, two other participants (Bev and James) were positive about their reports of their new communities after moving between waves 2 – 3. Each had some experience of these communities and regularly visited local shops. Bev had a negative perspective on her neighbourhood prior to moving, along with five other participants who had a negative perspective on their neighbourhood (Jimmy, Lenny, Linda, Arnie, Lyla). For each of these individuals, neighbours hindered their progress towards outcomes in a range of ways. The prominent influence of neighbours challenges the findings of Boyce (2006) who suggests that there is still debate about how much contact anyone has with the people that they live geographically close to (Boyce, 2006). The following two quotes highlight significant differences in the influence of neighbours:

“So I’ve moved over there and it’s like a fresh start really, you know what I mean. Fortunately the street where I live, you can hear a pin drop.

Now the two neighbours on that side and the one downstairs, every time I see them it’s ‘ah, you alright?’. He give is a lift up into town. They’ve said to is if you ever need a run up to your mam’s in an emergency and I’m thinking, you never get neighbours like this anymore. So it’s nice.”

(Joseph. Positive trajectory)

“It’s right on top of is, constantly. I’ve got 3 drug dealers in my street, there’s 2 drug dealers just across in the next street, then behind is there’s another 2 drug dealers. It’s just tempting all the time ... Banging on the door, middle of the night,

twos and threes in the morning ... If you don't let them in they start kicking your doors and things like that."

(Lenny. Static trajectory)

The remaining two participants did not engage with their local community, commonly staying in their flat and had a neutral opinion. It is also worth noting that Liam, along with Arnie had a more positive opinion of their accommodation, but this diminished over time. In Arnie's case this was due to the negative impact of neighbours with similar substance misuse issues. For Liam this may be attributed to health issues, which restricted his capacity to go out into his community, particularly as he was in an upstairs flat. The relationship between physical mobility and community integration was particularly prominent for those participants categorised as 'ageing drinkers' (see section 6.3.3) and is discussed further in section 7.3.3.

Evidence provided here provides some answers to Quilgars and Pleace's (2016) question of whether social integration is a realistic aim for HF. Some HF clients may be able to gain social integration in their destination communities, whereas face greater challenges in doing so. Of course, social integration goes further than an individual's general sense of social trust, or their perception of their neighbourhood. It also involves individual's ability to take part in the full range of activities and opportunities available to the general population (Yanos et al., 2004: 134). Section 5.4.8 explores some of these activities.

5.4.8: Meaningful Activities

In this study, participants' engagement in 'meaningful activities' was defined in terms of formal and informal employment or volunteering as well as any form of education and training. Evidence of engagement in meaningful activities was gathered through qualitative questioning at each wave. These 'meaningful activities' are understood as

opportunities for further social inclusion³⁸. Exploring the extent to which participants engaged in these activities is therefore indicative of 'successful' outcomes. Section 7.3 discusses inequities in participants' abilities to access these activities.

Findings from this study were in line with other studies which have suggested very limited progress around overcoming long term unemployment through HF (Waegemakers Schiff & Rook, 2012; Woodhall-Melnik & Dunn, 2015). No participants had gained formal employment, and only one participant had engaged in a form of informal employment, working as a gardener for his brother (Johnny). Johnny was also the only participant actively seeking work, as well as being the only participant who was required to do so as a result of receiving benefits through job seekers allowance (JSA) rather than employment support allowance (ESA).

Johnny also engaged in a formal computer course to assist with his job searching. Gary was the only other participant to engage in a formal course. However, this does not necessarily represent a positive change, as Gary's case manager advised against the course which was distance learning, computer based (Gary doesn't have regular access to a computer) and cost more than Gary could afford.

As so few participants were engaged in employment, volunteering, education or training it is worth briefly exploring whether participants desired to engage in these activities. Although many participants expressed that their top priorities were to reach employment, many did not see pursuing meaningful activities as an immediate priority. Instead, they wished to overcome their substance misuse or mental health needs, and maintain their tenancies. As such, only five participants reported that they were actively considering engaging in informal education or training in the near future (Bev, Carl, James, Lisa, Linda). Amongst this group, only Bev and Carl had explored particular education providers.

³⁸ See section 3.5.3 for further discussion of the role of opportunities in influencing the capacity for choice and control

5.5: Conclusion

As highlighted throughout section 5.4, outcomes for participants were in line with those reported in other implementations of HF (Waegemakers-Schiff & Rook, 2012; Woodhall-Melnik & Dunn 2015) (see sections 2.5 and 2.6). The most positive outcomes were around housing retention and improved mental health. However, qualitative findings highlighted that housing retention rates, so often noted as ‘headlines’ in HF evaluations masked considerable variation in participants’ capacity for ‘home making’ and the increased stability and security this often represents.

Qualitative findings did highlight some important changes in each domain which although small, and subjective still represent ‘successes’ for this group. In particular substance misuse outcomes demonstrate that some participants were able to gain greater control over their usage, or desist from particularly harmful substances. The challenging, complex, and dynamic nature of desistance and recovery processes may explain why positive outcomes had not been clearly achieved. Processes of change are long, and small steps forward may prove significant in the longer term.

The other key conclusion to make is that even amongst discussion of general trends, considerable variation emerged between participants. It is worth exploring why some participants consistently gained more positive outcomes (as demonstrated in discussion of participants’ outcome trajectories in section 5.3.1). Some participants seem to have been able to utilise the foundation provided by HF, while others have not. There was therefore clear variance in the capacity of participants to utilise the ‘choice & control’ offered by the HF service to pursue a subjectively meaningful and positive life.

It is crucial to the aims of this thesis to explore the factors that influenced participants’ capacity to utilise choice and control to achieve success on their terms. In line with the ‘situational approach’ outlined in Chapter 3, the key personal and environmental factors which influenced choice are explored in the following two chapters with explicit reference to how they influenced participants’ outcome trajectories. Chapter 6

explores the life histories of participants, highlighting considerable variation in the extent of participants' needs and capabilities. These variations form the basis of a typology which differentiates participants into one of four clusters. Chapter 7 then focuses on environmental factors influencing participants' capacity for choice and control. The typology developed in Chapter 6 is used to demonstrate the differences as to how far, and in which ways, these environmental factors influenced participants. Specifically, it demonstrates that those participants with more challenging and complex life histories tend to face greater environmental barriers to exercising choice and control, and achieving positive trajectories.

6: Personal Analysis of Capacity for ‘Choice and Control’

6.1: Introduction

This chapter explores *the biographical factors that affect clients’ ability to utilise ‘choice and control’ to achieve desirable outcomes.*

As outlined in section 2.7.5, a key contention amongst proponents of HF is that offering ‘choice and control’ to MEH adults promotes favourable outcomes (Padgett et al., 2006). The model aims to allow clients to have greater control over their lives through the mechanism of choice. In doing so, HF positions clients as actors who can direct change through consumer type choices (see section 3.2).

In contrast, explanations of homelessness often position MEH adults as either making immoral choices or lacking the capacity to make choices altogether (Parsell & Parsell, 2012). If MEH adults are conceived as having largely made ‘bad’ choices about their lives to this point, it would seem counterintuitive to assume that offering higher levels of choice and control would bring favourable outcomes. This disconnect can be partly explained by a lack of literature which adequately explores the agency (personal choice) of homeless adults generally. In turn, the existing literature focuses primarily on the causation of homelessness rather than the exit from homelessness (McNaughton Nicholls, 2009). This chapter aims to contribute to this gap in knowledge by undertaking an in depth analysis of the personal factors which can influence MEH adults choices in the context of exiting homelessness.

Of particular concern is clients’ ability to utilise the foundation provided by HF to move towards recovery and desistance, broadly defined as overcoming needs and achieving a subjectively positive and meaningful life. The trajectories identified in section 5.3, highlighted considerable difference in participant’s capacity to do so.

The chapter relies mainly on analysis of participants’ own accounts of their life histories. In line with the situational approach outlined in figure 3.1 (section 3.5), relevant

personal factors were categorised as ‘needs’ and ‘capabilities’, which were further categorised into particular domains (e.g. substance misuse, previous experience of tenancy sustainment). Preferences were also highlighted as important factors influencing participants’ choices in section 3.5.2. Preferences were discussed in relation to participants’ priorities in the previous chapter. In this chapter, participants’ *‘transgressive preferences for action’* are interwoven into analysis and discussion of the ‘needs’ and ‘capabilities’ they contribute to.

Each ‘need’ and ‘capability’ is considered individually in Appendix B.2 with differences highlighted in participants’ experiences of each. This chapter focuses on the typology that emerged from this analysis. Based on the differences in participants’ experiences, section 6.3 identifies four ‘types’ of life histories, each of which present a different set of needs and capabilities. As well as the extent to which participants experienced each, the temporal sequencing of different needs and capabilities are considered further in this section. When compared with participants’ outcome trajectories in the HF service, the typology is found to be highly predictive. However, this is not to say that personal factors alone predicted participants’ capacity for choice and control. Environmental factors also played an important role and are considered further in Chapter 7.

Before exploring the personal factors influencing individual’s capacity to utilise choice to bring about favourable outcomes, section 6.2 explores participants’ subjective perceptions of choice and control in HF. It is important to establish whether participants perceived themselves to have choice and control, as studies promoting choice in HF primarily rely on quantitatively orientated assessments of perceived choice (Tsemberis et al., 2004; Greenwood et al., 2005). Qualitative findings in this study are in keeping with other studies. However, these findings also highlight important considerations around participants’ point of comparison when making such assessments.

6.2: General Sense of Choice

As noted in the introduction, section 6.3 of this chapter explores the incidence of personal factors that can affect participants' capacity to actually *utilise* 'choice and control' to achieve recovery and desistance orientated outcomes, with a great deal of variation identified.

This section focuses on participants' *perceived* sense of choice over three key areas in which choice is offered in HF; housing, support and behaviour (Gilmer et al., 2013). It is important to explore participants' perceived sense of choice to see whether these less tangible measures of success correlate with analysis of participants' capacity to utilise choice³⁹ (Sen, 1993). The evidence presented shows that in comparison to their time spent in hostels, all participants felt a greater sense of choice and control in their HF tenancy. These findings provide further support for the contention that situating individual's recovery in the community enables more freedom than institutional settings (Goodman et al., 1991; Lamb, 1993, Ridgway & Zippel, 1990). Positive qualitative reports of perceived choice are also in keeping with quantitative findings from other studies that have linked perceived choice to positive outcomes (Greenwood et al., 2005; Nelson et al., 2007; Tsemberis et al., 2004).

6.2.2: Perceived Choice over Housing

Participants' perception of choice over housing was elicited through qualitative questioning, and in the first instance focused on choice over housing location and quality. When asked, the majority of clients felt that they had choice over their housing in terms of where the housing was located and whether they had the option of viewing the property before moving in. The question of whether clients *engaged* with choice was less clear.

³⁹ See section 3.5.2 under 'The Capabilities of MEH Actors' for discussion of importance of going beyond intangible measures of 'success'.

When asked, the majority of clients and case managers did not see private rented as the most secure tenure, most would have preferred to be in social housing. Each perceived social housing offering greater security and housing quality. However, case managers were realistic about the prospects of many in accessing social housing prior to the private rented sector (PRS):

“My thought is if we put them in PRS to start with because lots of them can’t get council properties, because of previous histories, either what convictions they’ve had ... So what you need is a good housing reference, and you can only get that from a private tenancy. So the idea is to put them in a private tenancy for a minimum of 6 month, then you start to make an application to proper council flats.”
(Case Manager)

After encouragement from case managers, PRS was perceived as a necessary step towards a more favourable housing tenure. Although PRS was not many participants ideal housing tenure, it was still perceived as favourable to their current homeless situation. For these reasons, the majority of clients took the first property offered:

Interviewer: “Did you view this place before you moved in?”

Yeah I come with [service manager], and I just went (disappointed noise), but I just wanted to get out the hostel.”

(Bev. Positive Trajectory)

Armed with a situational understanding of decision making we can see that participants’ negative perceptions of homeless hostels encouraged a less deliberative choice process. The mechanism of choice as a means of achieving more subjectively appropriate housing is dependent on participants’ ability to reject less desirable options in favour of those that are more desirable. Yet, to almost all participants any independent housing was favourable to the ‘action alternative’ of remaining in hostels.

6.2.3: Perceived Choice over Support

When asked, all participants felt that they were afforded choice and control in their relationship with their case manager, conceptualising this in two ways.

Firstly, participants could determine when they saw their case manager. Participants could determine which days the case manager visited and support workers would contact participants in advance to confirm appointments. One case manager highlighted the flexibility of most:

“It’s just ad hoc, I work around them, some I say I’ll see you every Tuesday and they know that. One girl she’s started a new club on a Tuesday and a Thursday so I’ve changed her day to a Friday, so I mean it’s up to them isn’t it?”

(Case Manager)

My own experience of ‘going along’ (Kusenbach, 2003) with case managers to visit participants always began with a phone call to ensure the participant was in, happy for us to come around, and if not (as was often the case) when they would like us to visit. Consequently, participants had the capacity to refuse support to an even greater level than is afforded in ‘pathways’ models of HF, in which clients are required to engage with their support worker at least 6 times a month (Tsemberis, 2010).

The second way in which participants understood themselves to have a greater degree of choice and control was in reference to their relationship with their case manager. In retrospective accounts of their time in hostels, staff were commonly perceived as individuals who enforced rules and collected rent payments. Consequently, the power relationship between clients and staff was imbalanced in the favour of the staff. When asked about their relationship with their case manager in HF, participants responded in very different ways. However, they consistently positioned their case manager as someone who could ‘help them out’ with tasks that they weren’t comfortable with, because they didn’t lie within their current capabilities, best articulated by James:

Aye, aye. It's anything I need help with and all that and if I need to get in touch with, so the dole, or things like that or if I've got a problem, he'll ring up and he speaks on me behalf and all that and just stuff like that.

(James. Fluctuating Trajectory)

Participants directed what the case manager would help them with (this was almost always bills or benefits related paperwork). As one case manager put it:

"Everything I do is client led. I say you tell me what you want and ill help you achieve it. I don't try to force anything because my opinions might be different to theirs. What do you want to do today, if you don't want to pay your bills don't pay them, if you don't want to go to your doctor's appointment then don't. it's entirely led by them."

(Case Manager)

These findings support the contention that choice is an effective mechanism for addressing the power imbalance brought about in more paternalistic models of service provision, as often exemplified in linear residential treatment models (Ridgway & Zippel, 1990; Tsemberis et al., 2004). However, offering more choice to clients did not necessarily lead to better outcomes or even happier clients. In line with other studies, welfare decisions essential in tenancy sustainment were stressful for most participants (Baxter & Glendinning, 2013). As a result, the responsibility associated to having greater choice and control over their own housing and finance caused tension in the relationship between some participants and their case manager:

Case Manager: "That's what you've got to pay every fortnight now, £18 instead of £10."

"See that's what I mean, I f**king hate being in a house ... Come on, compromise with me, compromise, don't talk sh*t, go get me a fag"

(Jimmy. Static Trajectory)

All participants entered HF tenancies after spending significant periods in hostel accommodation or rough sleeping, albeit to varying degrees. In hostel accommodation, staff possessed greater capacity to directly influence participants' financial problems. In hostels all utility bills were included into the cost of accommodation, paid directly to the provider through housing benefit. This meant that participants were not responsible for these activities. Interestingly, a small of participants with static trajectories who had histories containing long experiences of rough sleeping (categorised as 'ageing drinkers' in section 6.3.3), seemed to experience more tension with their case manager over bills. These 'ageing drinkers' compared their time in HF with long periods spent rough sleeping, during which they had very few responsibilities, and subjectively high levels of autonomy:

"Well I had a lot more freedom on the streets, cos with the flat like everything at the moment just goes in the flat you know what I mean."

(Lenny. Static Trajectory)

"This is me, since November, paying my gas, electricity, TV license, I've actually pinned it up, it cost me a fortune ... I never had these problems on the street, you know."

(Jimmy. Static Trajectory)

For these participants in particular, the focus on choice and control in HF was less favourable. These findings offer some support to the contention that HF may represent a liberal method of shifting responsibility to the client (Löfstrand & Juhila, 2012). Central to these critiques of 'choice' is the argument that choice privileges those with capabilities in line with mainstream social norms (Holland & Thomson, 2009; Rose & Miller, 2008) (see section 2.7.5). For these participants, rebalancing power relations in favour of the client may be less effective or humane (Padgett et al., 2006), as ultimately, some clients have less relevant capabilities to draw on than others do. As a result, they find these tasks more stressful.

Nevertheless, upon reflection, participants generally perceived that the security, stability, and favourable material conditions of having a flat largely balanced out the range of tasks needed to maintain it. As Lenny succinctly put it:

“I like the streets but I wanna be in the flat more.”

(Lenny. Static Trajectory)

6.2.4: Perceived Choice over Behaviour

As with reference to housing and support, participants consistently used their time in hostels as a point of comparison when describing perceived choice over their behaviour in HF. With the exception of those ‘ageing drinkers’ described above, the overarching trend across the responses of participants was that having their own independent space afforded them greater choice over their behaviour, usually conceptualised in terms of greater autonomy. A greater level of autonomy was described by many as a lack of conditions, which most had experienced in hostels:

“Cos like some hostels you’ve got like a curfew when you’ve got to be in and all that ... then you’re only allowed so many nights out, so you’re restricted to things you can do. Here, you can do what you want, when you want”

(Lisa. Positive Trajectory)

The extent to which participants could actually do *‘what they wanted to do, when they wanted to do it’* was restricted in other ways, as highlighted in 7.2. For now, it is relevant to note that *‘what participants wanted to do’* varied. The HF principle of employing a harm reduction approach to substance use (see section 2.7.2) implies that participants do not face conditions of abstinence or sobriety from the service, in turn possessing greater control over these behaviours. For the minority of participants (n=4) their substance use increased after moving into their HF tenancy. However, only Gary attributed this to a personal choice:

Interviewer: “You said you like a drink, you like a smoke. Has that changed since you’ve gone into your own place?”

“Ah, no, no, I’ve embraced it more (laughs)”

Interviewer: “Ah right ok, why do you think that is?”

“err, just my own space, time and enjoyment. It’s just what I enjoy doing.”

In sharp contrast, Linda described her greater sense of autonomy in terms of being able to:

“Like dee things for yourself, like cleaning up and doing your own dishes and that, you would hardly be able to do that in a hostel”

(Linda. Fluctuating Trajectory)

Many participants also described a greater sense of control over who entered their property. In contrast to hostels, where anyone could walk in, participants felt that they had greater security and ownership over their accommodation.

“..I still drink and everything obviously, but like, in hostels it’s in your face all the time. Whereas in here (independent tenancy) I can just close the door and relax”

(James. Fluctuating Trajectory)

James’ quote represents the responses of many in describing how fellow hostel residents and homeless associates more generally encouraged harmful behaviours. We can understand the influence of these associates as being representative of norms of substance use and violence in hostels (Ravenhill, 2012) (as discussed in section 3.5.3). The influence of these norms can be understood further through Wikström’s (2014) two types of motivators: temptation and provocation (see section 3.5.1). In participants’ retrospective accounts, associates were consistently positioned as either tempting participants’ to engage in substance misuse, or provoking them to engage in aggression or violence, both of which usually resulted in negative consequences. Many participants described that, over time, living in close proximity led them to feel like they were trapped in affective behavioural cycles, developing and habitually selecting particular action alternatives through automatic choice processes when faced with these same motivators.

“Oh me own place, it was, aye, it was really difficult because I was used to being around people constantly and it’s, I dunno, it’s like a web, you get trapped in it, you get used to it being your life, you know.”

(Carl. Fluctuating Trajectory)

All but one participant (Arnie) saw their HF tenancy as an opportunity to separate from these subjectively negative motivators and habitual processes. However, the extent to which participants were able to take advantage of, and sustain this opportunity varied, as outlined in section 6.3.

6.2.5: Conclusion on Perceived Choice

It was clear that when asked, participants generally perceived that they felt that they had a greater sense of choice and control over housing, support and behaviour in HF. However, their consistent point of comparison was their previous living situation in homeless hostels in which, by design, they were afforded very little choice and control due to being conceived as ‘deviant’ or ‘incapable’ (see section 2.3).

As demonstrated in section 2.2, the model emerged from critiques of a ‘treatment first’ philosophy and was designed as an alternative to this approach. In turn, rather than trapping individuals in cycles of homelessness the model aimed to use housing as the foundation for support. In turn, ‘choice and control’ was employed as the means of guiding that support to meet subjectively favourable outcomes related to other needs (see section 2.7.5). Therefore, it is necessary to go beyond whether participants subjectively *perceived* that they had more choice in HF than in hostels and explore whether participants were able to utilise the choice afforded to them to gain greater control and move towards desirable outcomes. Doing so, unpicks the lived experiences that lie behind the principles of HF to identify how they manifest in a particular context (Atherton & McNaughton Nicholls, 2008; Raitakari & Juhila, 2015).

The remainder of this chapter discusses the personal factors that influence participants' capacity for making choices towards recovery and desistance in the context of HF. Section 6.3 outlines a typology of participants that has emerged from analysis of factors in participants' life histories that can affect their ability to make these choices.

6.3: A Typology of Participants 'Needs' and 'Capabilities'

In this section, four 'types' of life histories are highlighted amongst participants. Each 'type' representing distinct strengths and challenges in their personal capacity to utilise choice and control in HF to achieve recovery and desistance orientated outcomes. Subsequently, section 6.4 shows this typology to be predictive of particular outcome trajectories outlined in Chapter 5.

The analysis that this section is based upon, relies heavily on participants' own accounts of their life histories. This is deemed the best way to understand the personal factors that influence an individual's capacity for choice. (Kahneman, 2011; McNaughton Nicholls, 2009; Wikström, 2014). A more thorough outline of the methods used to gather and analyse these life histories can be found in 4.4.1 (data collection) and 4.5.2 (analysis). For context, a more thorough analysis and discussion of particular domains of 'needs' (e.g. substance misuse, trauma) and 'capabilities' (e.g. tenancy sustainment experience) can be found in Appendix B.2. This section will focus on the typology that emerged from this analysis and differentiated four clusters of participants.

Exploring adverse experiences and needs in the personal histories of MEH individuals is common. Exploring the capabilities or strengths of MEH adults is less common, particularly in evaluative literature. However, incorporating participants' relevant capabilities into the analysis is in line with a situational approach, which highlights the importance of capabilities in influencing an individual's choices. In turn, incorporating capabilities fits with a strength based approach emphasised in conceptualisations of success in mental health and substance misuse recovery literature (White, 2007; Homeless Link, 2016). Following on from this the use of capabilities aligns with Sen's

(1993) approach to personalising the measurement of wellbeing according to what people are capable of (see section 3.5.2). By incorporating a capabilities approach within a situational analysis of individual's intertemporal choices, it is possible to identify variations in participants' capacity to pursue favourable outcomes, within the setting of a HF tenancy.

The capabilities used in this study are focused around what will enable achievement of desirable outcomes. Preferences were also highlighted as important factors influencing participants' choices in section 3.5. These are not discussed separately, and are instead interwoven with 'needs' and 'capabilities'. For example, a participants' behavioural preference to use a particular substance in terms of emotional stress also constitutes a wider need (Sinha, 2001; Maté, 2010). Further, the preference to engage in 'begging' can also constitute both a 'need' and 'capability' for some.

There were a number of commonalities in participants' experiences of relevant needs and capabilities. Firstly, all participants had experienced adverse life experiences. All had experienced some form of homelessness, substance use issues and mental health issues, and the majority had engaged in some form of street culture and/or offending. Only very few participants described any positive engagement or achievement in secondary education, and the employment histories of most participants were either non-existent or limited. Apart from Gary, all participants also described growing up, and living much of their lives in situations of relative poverty or socio economic disadvantage, which limited their opportunities and resources and contributing to their social exclusion (Gordon et al. 2000; Pleace, 1998; Sen 2000). Even for Gary his early childhood was lived in poverty, prior to his adoption.

However, participants' qualitative accounts of their personal histories highlighted a great deal of difference in the type and severity of adverse experiences, as well as the contrasting development of relevant personal capabilities for pursuing subjectively desirable outcomes. Amongst these differences, trends were identified in the experiences

of participants both through a process of comparing across individual domains and by identifying temporal trends in participants' experience of these domains⁴⁰. The result was the development of typology, specific to the participants in this study but also representative of the wider population of individuals facing 'severe and multiple disadvantage' and 'multiple exclusion homelessness'.

Clustering participants according to their needs is not an original contribution, either with reference to HF (Tsemberis, 2013), and within the MEH population more generally (Fitzpatrick et al., 2011, Fitzpatrick et al., 2012). Fitzpatrick et al., (2011) identified a high degree of overlap between experiences of homelessness, substance misuse, institutional care and 'street culture' activities. In a subsequent publication, they highlighted five experiential clusters within the MEH population based on the extent and complexity of the needs faced by these individuals, including the same criteria, with the addition of adverse life events (Fitzpatrick et al., 2012). In doing so, the authors identified experiences of childhood trauma related most closely to those with the most complex needs. However, in each case, analysis has focused primarily on individual's needs. In contrast, this study also includes the relevant capabilities participants possess.

It is important to recognise that every individual life story is distinct. Nevertheless, it is possible to identify similarities in the balance of needs and capabilities over the life course. Four 'types' of life histories emerged, each of which presenting particular needs and capabilities, which were unevenly supported by the HF service (explained throughout section 7.3). Tables 6.6 and 6.7 display the differences between the experiences of participants across relevant needs and capability domains. This section covers each 'type' in more detail as well as highlighting an individual case study.

Visualisations are included to highlight the incidence and temporal sequencing of relevant needs and capabilities through the life courses of participants. Participants are displayed in the vertical axis, with each participants' life course displayed in horizontal

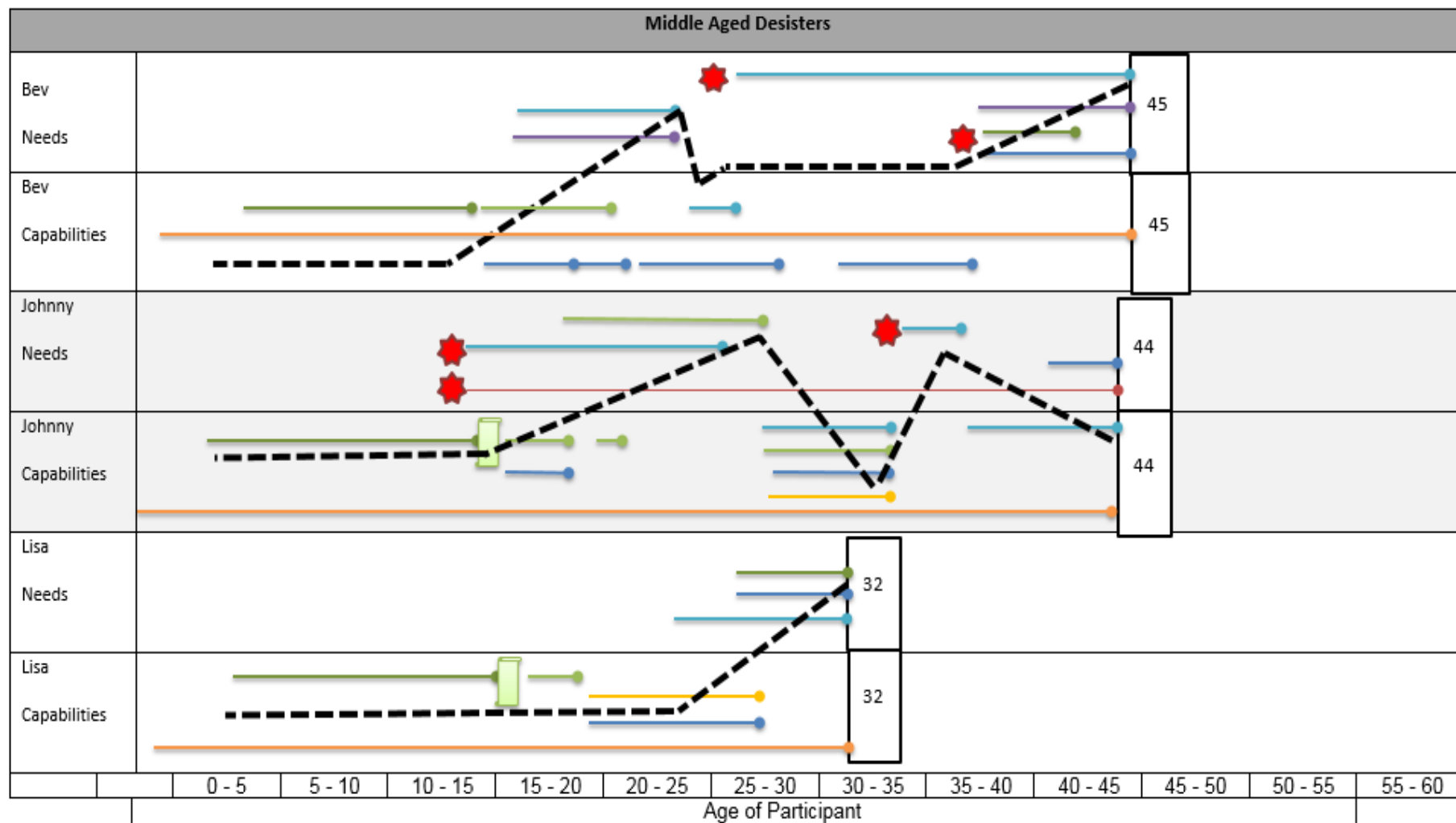
⁴⁰ Further explanation of this process can be found in section 4.4.2





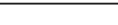


rows. Relevant needs and capabilities are displayed through colour coded lines and icons defined in the key. The length of the line indicates the length of time a participant described experiencing (and developing) that particular need or capability. The age at which needs or capabilities were developed is available by referring to the horizontal axis. Within these visualisations, the trend lines demonstrate the shift between periods in which participants' needs were particularly prominent and periods in which participants were able to develop relevant capabilities to support their recovery and desistance orientated choices in HF.










Table 6.1: The Extent of Needs in the Life Histories of Participants							
<u>Category</u>	<u>No. of Participants</u>	<u>Age</u>	<u>Substance Misuse</u>	<u>Mental & Physical Health</u>	<u>Traumatic Experience</u>	<u>Offending</u>	<u>Street Culture</u>
Middle Aged 'Desisters'	3	35 - 46	Single Issue (controlled)	Anxiety/ Moral Guilt	Limited	None/ Desisted	None
Young & Excluded	2	23 - 27	Single Issue (Binge use)	Anger Management/ AS PD	Parental loss/ emotional abuse	Limited offences related to theft and violence	Street Drinking
Ageing Drinkers	4	55 - 64	Chronic Alcohol Use	Depression, chronic physical health conditions	Mixed	Low Level Theft	Persistent Begging, rough sleeping and street drinking
Severely Dis-advantaged	5	28 - 39	High Levels of Poly Drug Use	Complex range of severe issues	Profound physical, sexual and emotional abuse	Persistent offences related to theft and violence	Persistent Begging, rough sleeping and street drinking


Table 6.2: The Extent of Capabilities in the Life Histories of Participants							
<u>Category</u>	<u>No. of Participants</u>	<u>Age</u>	<u>Educational Engagement</u>	<u>Tenancy Sustainment Experience</u>	<u>Subjectively positive, supportive relationships</u>	<u>Employment Experience</u>	<u>Period of SM Abstinence</u>
Middle Aged 'Desisters'	3	35 – 46	Completed School, few qualifications	Years of successful tenancy sustainment	Consistent and ongoing support from family	Some experience of employment	Achieved at least 2 years abstinence from previous SM issues
Young & Excluded	2	23 – 27	Limited educational engagement	Unsuccessful tenancy sustainment experience	Loose family ties, Mixed romantic relationships	No employment experience	Issues are 'binge' related
Ageing Drinkers	4	55 – 64	Regular educational engagement	No 'direct' experience (partners completed these tasks)	Very loose relationships with siblings at best	Regular employment until middle age	No/ only short periods of SM abstinence
Severely Dis-advantaged	5	28 – 39	None completed school	None/ unsuccessful	None (exc. Carl – loose ties with extended family)	None	None

Figure 6.1: Temporal Mapping of Needs and Capabilities in the Life Histories: 'Middle Aged Desisters'



Key of Relevant Participant Needs	
	Traumatic Experience and length of experience
	Hostel/ Street Homelessness
	Substance Misuse
	Mental Health Issues
	Offending
	Street Culture
	Age at Study Commencement

Key of Relevant Participant Capabilities	
	Positive, Subjectively supportive Romantic Relationship
	Successful Tenancy Maintenance
	Unsuccessful Tenancy Maintenance
	Period of SM Abstinence
	Period of Employment
	Regularly Attended School
	Achieved Qualifications
	Regular, subjectively positive familial contact
	Age at Study Commencement

Key of other Items	
	'Trend Line' Demonstrating the Balance of Needs and Capabilities

6.3.1: 'Middle Aged Desisters'

As suggested by the title, 'middle aged desisters' were middle aged, and had largely desisted from harmful behaviours prior to entering HF. The three participants in this type were Bev, Johnny and Lisa. Their needs were moderate in comparison with other groups. In turn, they were somewhat representative of Fitzpatrick et al.'s (2012) 'homelessness and mental health' cluster.

Each of these participants described a generally good childhood with positive, supportive parental relationships. In contrast to other participants, they did not experience neglect or abuse commonly associated to more severe mental health and substance use issues (Foege, 1998). In turn, all experienced positive support from their immediate family throughout their lives. None of these participants expressed particularly good engagement with school, or left with a high level of qualifications. Nevertheless, they all finished school and went on to work.

Each experienced issues in their transitions from adolescence to young adulthood, a period in which they faced increased responsibility. All left home and gained (low paid) employment, and entered romantic relationships. Bev and Johnny unintentionally had children during this period. All noted the stresses of this transition and entered periods in which various needs developed, albeit in different ways. Bev struggled with an eating disorder and a related amphetamine dependency. Lisa began using cannabis and alcohol more regularly then began using heroin out of curiosity. Johnny reported offending issues in addition to his drug use. In line with findings from other studies (Harold et al., 2016; Treanor, 2015), accumulated stress from positions of responsibility set within a context of socio economic disadvantage (employment, parenthood) was common across each the experiences of participants. This stress combined with temptation from friends and associates to engage in substance use (and crime in Johnny's case).

“Just getting in with the wrong people and that, just having a bit of a sh**ty life and that, then I just hit the drugs.”

(Lisa. Positive Trajectory)

“No I didn’t have to use them, but the certain place I’ve been brought up and the people around is, they were available and things like, you know, and that’s what I knew.”

(Johnny. Positive Trajectory)

At any given time, substance use issues were singular, and both Bev and Johnny demonstrated a capacity to desist from these behaviours for periods of time (see figure 6.1).

Throughout their twenties, these participants engaged in these behaviours before experiencing periods of desistance in early middle age. Throughout these periods, participants were able to develop relevant capabilities around successfully retaining flats, employment, and understanding the process of desisting or being in recovery.

Lisa did not report any traumatic events in her life, and Bev and Johnny faced traumatic events but these could be considered less severe than those faced by other participants. In turn, the mental health issues of each were aligned to feelings that they had disappointed their parents, failed their children or under achieved in life more generally. As such, their mental health issues are commonly related to depression and moral guilt at their own behaviours.

“I’ve thought nar, can’t go on like this, you nar, you’re 42 year old. You’ve got a mam poorly, and I’m putting myself on the stuff, well how’s that fair”

(Johnny. Positive Trajectory)

Depression can restrict the motivation required to engage in deliberative choice processes. Depression inherently inhibits an individual’s capacity for motivation. In turn, a lack of motivation may lead to participants’ deferring important choices about their recovery (Keat et al., 1994). However, role of moral guilt in the cases of these participants

seemed to offer a significant motivator for pursuing pro social roles and better relationships with family. A sense of moral guilt also indicates that participants were aware that their substance use issues and offending behaviours were transgressive, having internalised wider social norms (Elster, 2009).

For all participants their period in a homeless situation was at least in part initiated by relationship breakdown. Their experience of homelessness is comparatively short lived and is associated to hostels, with few exclusions. In turn, their immersion in 'street culture' was limited in comparison with other 'types'. Consequently, these participants had not internalised the norms of behaviour associated to this culture into their own habitual choice processes (Kahneman & Tversky, 2000; Wikström, 2004)⁴¹.

In contrast, a tenancy is a situation that has a degree of familiarity for these participants. Each participant has well developed experiences of tenancy sustainment and of engaging in pro social roles. In turn, each possess comparatively well developed capabilities for pursuing their personal priorities.

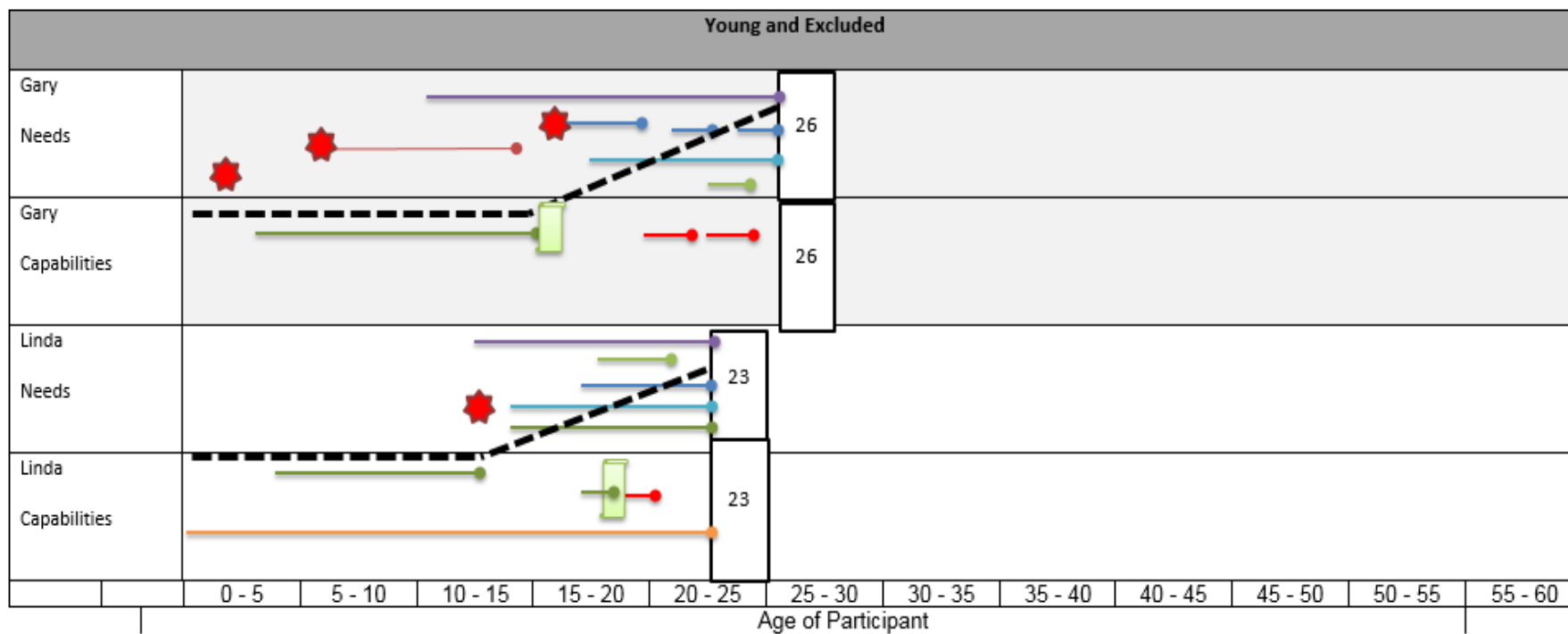
However, these participants also bring relatively high levels of positive social support from their family which, as highlighted in 7.3.1 supplemented their own capabilities. The results were particularly positive for this 'type', Johnny felt able to actively search for work, Bev had access to her children who lived with her parents and Lisa had a new born son who she was receiving support to care for from her immediate family. Figure 6.9 now offers Johnny's biography as an example of a 'middle aged desisters' life history.


















⁴¹ See section 3.5.1 (habitual choice processes) for definition and further discussion of these concepts

Figure 6.2: A Case Study of Johnny

Childhood (0 – 13 years)	Describes a happy childhood and notes that he has very good parents and brother. He grew up in a disadvantaged area in which crime and substance use were visible and common
Adolescence (13 – 18 years)	Limited engagement with secondary school. He regularly attended but was known for poor behaviour.
	At 15, two of Johnny's friends died in a traffic accident. In the same year his mother was diagnosed with cancer. Johnny notes that he already used alcohol and drugs recreationally, but use increased at this point.
Young Adulthood (18 – 30)	After finishing school Johnny worked as a panel beater at a car garage. Johnny also got involved with criminal networks, engaging in theft and associated crimes.
	From 19 – 29 Johnny spent a total of 7 years in prison, repeatedly breaching probation conditions due to his associations. Briefly working as a chef during an early spell out of prison. He met his first partner at age 20, and had the first of two sons at age 22.
	At 29, Johnny's relationship broke down and he moved to York to separate from his criminal associations.
	Having developed his skills in prison and during a brief spell of employment, Johnny gained work as an agency chef and met his second partner. They moved into a flat together in York and lived there for around 5 years.
Middle Age (30 – 44)	Johnny's relationship broke down. Johnny began using heroin as an emotional painkiller. He used heroin regularly for 2 years before successfully transitioning to a methadone script.
	Johnny's mother's cancer returned. Struggling to afford rent in York he moved back to Newcastle. He stayed with his parents briefly but 'chose' to become homeless to ease the burden on them.
	After initially rough sleeping, Johnny then gained accommodation in a direct access hostel where he spent 3 years. He volunteered as a chef throughout this period to maintain separation from the perceived temptation of other homeless associates.
	Johnny entered his Housing First tenancy in October 2014, age 44.

Figure 6.3: Temporal Mapping of Needs and Capabilities in the Life Histories: 'Young & Excluded'



Key of Relevant Participant Needs		Key of Relevant Participant Capabilities	
	Traumatic Experience and length of experience		Positive, Subjectively supportive Romantic Relationship
	Hostel/ Street Homelessness		Successful Tenancy Maintenance
	Substance Misuse		Unsuccessful Tenancy Maintenance
	Mental Health Issues		Period of SM Abstinence
	Offending		Period of Employment
	Street Culture		Regularly Attended School
	Age at Study Commencement		Achieved Qualifications
			Regular, subjectively positive familial contact
			Age at Study Commencement
Key of other Items			
		'Trend Line' Demonstrating the Balance of Needs and Capabilities	

6.3.2: 'Young and Excluded'

The 'young and excluded' constitute the smallest 'type' of participants in this study, with only two participants included in this analysis; Gary and Linda. However, there was one more participant excluded from analysis who, given the data available also fitted in this 'type'. This group could be associated to Fitzpatrick et al.'s (2012) 'homelessness, mental health and victimisation' cluster in the wider MEH population. However, in this study they are referred to as 'young and excluded'.

Gary and Linda each faced traumatic experiences related to parental loss in childhood or early adolescence, both common 'adverse childhood experiences' in the ACE study (Felitti et al., 1998). For Gary, this was being given up for adoption, for Linda her father dying. In turn, each faced some form of neglect by their parents. Linda's mother largely neglected her after the death of Linda's father. Gary's parents followed medical advice on placed him on high doses of Ritalin through his childhood. To Gary, this separated him from reality and made him feel like he was being controlled, rather than loved (Van der Kolk, 2015).

"Like when we dad died, me ma couldn't like cope."
(Linda. Fluctuating Trajectory)

I'm more controlled now but to say that it doesn't affect me would be a lie. It affects me massively, it affects me hugely. I think on day to day why they gave me those drugs.
(Gary. Fluctuating Trajectory)

During their teenage years, each developed mental health problems particularly associated to control and anger management issues that have continued to affect their lives. Both left home at 17 and became homeless. Their homelessness is short lived and is confined to hostel living, with some short periods of rough sleeping for Linda. However, exclusions are common, commonly for violence and aggression when faced with

provocation by other hostel residents. Further, each experienced short periods in prison for offences related to violence.

“Like I would step up and say something, and if they didn’t listen id end up hitting them”

(Linda. Fluctuating Trajectory)

“I ended up snapping, I opened me door, I said what the fuck are you doing ... so I went downstairs and I said the next fucking person who does that to me, I’m gonna punch their fucking face in.”

(Gary. Fluctuating Trajectory)

Neither has moved into ‘painkiller’ type drugs (Maté, 2010) instead choosing more conventional drugs such as cannabis, alcohol and ‘new drugs’ such as mephedrone (Neptune, 2015).

Both have achieved some form of qualifications that give them capabilities for employment, albeit Linda’s were achieved in prison. Both have also moved into independent accommodation through other pathways, but failed to manage this successfully with both being evicted. Overall, the most significant needs posed by these individuals are there issues with control and anger management, as well as their affective ‘binge’ related issues with alcohol.

“She usually drinks for 3 or 4 days, she can’t stop when she starts.”

(Linda’s partner)

“This is my interpretation of life ... you can’t force anyone to do anything they don’t want to, because your just backing an animal into a cage which eventually will bite you, you know.”

(Gary. Fluctuating Trajectory)

“Just generally I’ve got quite a bad temper in high pressure situations. So like any jobs that are quite fast paced, which most jobs are ... In those situations I’m not equipped with being shouted at or dictated to in such a way that is antagonising.

So if I feel that it is antagonising even if it's a manager or what not, that won't bother me, I'll just fly off the handle and that means I lose my job."

(Gary. Fluctuating Trajectory)

Indeed, for each these were the primary causes of periods of relapse in their trajectories (see section 5.3.1). As explained in Appendix B.2.1, anger management issues reported by 'young and excluded' participants increase the likelihood that when faced with provocation, these participants will select an affective, automatic choice process in which they favour immediate response over a deliberative, restrained and 'civilised' response favoured by wider social norms and replicated in legal norms (Freese, 2009)⁴².

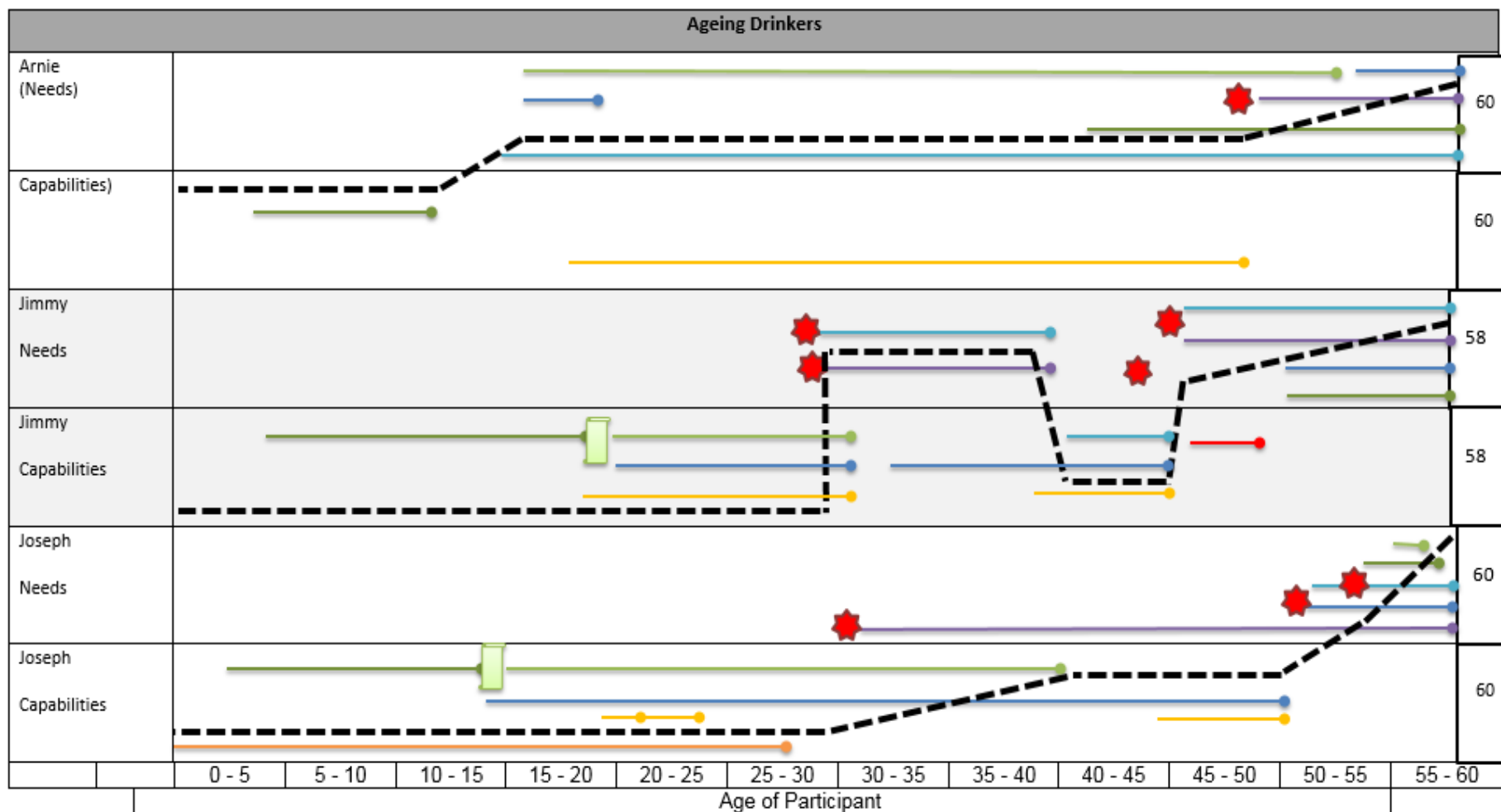
For Gary in particular, his childhood and adolescent experiences represent a significant hindrance to his capacity for self-control (Maté, 2010; Siegel, 2001). In turn, when faced with environmental cues that he perceives as another individual trying to control him, he consistently perceived these as provocation and reacted with aggression (see section 7.3.2). Figure 6.4 now offers Linda's biography as an example of a 'young and excluded' life history.

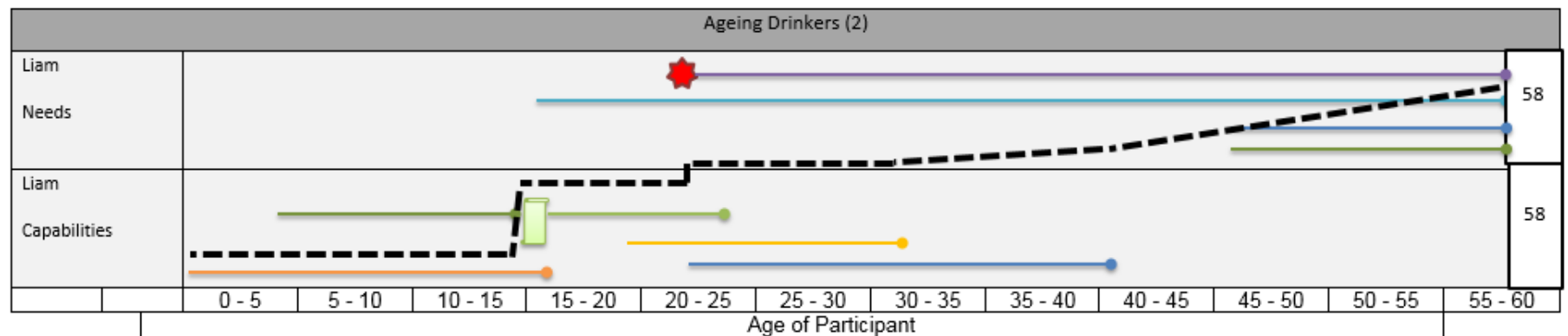
⁴² See section 3.5.2 for discussion of behavioural preferences and how these preferences can conflict with wider social norms.

Figure 6.4: A Case Study of Linda

Childhood (0 – 13 years)	Born and grew up in a 'rough' suburb of Newcastle. All of her siblings spent time in prison.
Adolescence (13 – 18 years)	<p>Father died when Linda was 13. Soon after this Linda began drinking and was evicted from a mainstream secondary school for violence towards teachers.</p> <p>Linda was moved to a special 'behavioural' school which she enjoyed. However, she stopped attending in year 9.</p> <p>Linda began socialising with older associates in her neighbourhood and began drinking more heavily. She engaged in low level crime and some 'cash in hand' work for her uncle.</p> <p>Linda spent time between youth homeless hostels and her grandmother's house in her mid – late teens.</p> <p>She gained a social housing tenancy at 17 but lost this due to anti-social behaviour and damage from parties.</p>
Young Adulthood (18 – 23)	<p>Linda spent her first spell of less than a year in prison at age 18. She later returned from breaching her conditions of release.</p> <p>Linda spent the next 3 – 4 years between various homeless situations, staying with friends, her grandmother or rough sleeping after being evicted from hostels for violent behaviour.</p> <p>Throughout her time in homeless situations Linda would go on regular alcohol 'binges' of 3 – 4 days at a time, noting regular temptation from associates.</p> <p>Linda met her current partner and began looking for PRS tenancies with her.</p> <p>Linda's Housing First case manager referred her into Housing First after knowing her for many years, and formerly working with her sister</p>

Figure 6.5: Temporal Mapping of Needs and Capabilities in the Life Histories: ‘Ageing Drinkers’





Key of Relevant Participant Needs	
	Traumatic Experience and length of experience
	Hostel/ Street Homelessness
	Substance Misuse
	Mental Health Issues
	Offending
	Street Culture
	Age at Study Commencement

Key of Relevant Participant Capabilities	
	Positive, Subjectively supportive Romantic Relationship
	Successful Tenancy Maintenance
	Unsuccessful Tenancy Maintenance
	Period of SM Abstinence
	Period of Employment
	Regularly Attended School
	Achieved Qualifications
	Regular, subjectively positive familial contact
	Age at Study Commencement

Key of other Items	
	'Trend Line' Demonstrating the Balance of Needs and Capabilities

6.3.3: 'Ageing Drinkers'

There were four participants who were grouped together as 'ageing drinkers'; Arnie, Jimmy, Joseph and Liam. Each were in their late 50's or early 60's and presented considerable physical health issues associated to long histories of alcoholism and rough sleeping. This group bore close resemblance to Fitzpatrick et al.'s (2012) 'homelessness and street drinking' cluster both in terms of their primary substance use issue and age.

All of these participants described growing up in relative poverty, with Arnie and Jimmy describing growing up in 'slum' areas of Newcastle and Glasgow respectively. Arnie and Jimmy noted the negative (but not abusive) influence of their fathers, mitigated to some extent by mostly positive relationships with their mothers.

"I wasn't very good at school at the time, I was more trying to make ends meet with my mother being on the dole and having the kids, it was hard to struggle, my dad never worked in his life, never! He knew how to get pissed every night."

(Jimmy. Static Trajectory)

An attachment relationship with at least one reliably available, protective, psychologically present and reasonably non-stressed adult is essential for childhood development (Siegel, 2001; Maté, 2010). Joseph seems to have lacked this relationship, as a single mother who suffered from anxiety and depression (later being hospitalised) brought him up. Treanor (2015) demonstrated the detrimental impact maternal stress can have on children. Liam had a good relationship with his parents but left home to join the Army at 15. All had loose ties to extended family in place as they entered HF. However, through participants' descriptions these could not be considered positive or supportive. As such, they did not constitute 'protective' factors in recovery or desistance (EnglandKennedy & Horton, 2011; Topor et al., 2006; Walker et al., 2013).

All participants experienced employment of some sort, although Arnie's was so short lived and early in life that it cannot be reasonably considered as representing a capability for pursuing outcomes through HF. However, Jimmy, Joseph, and Liam all had

long experiences of employment and housing throughout their 20's and 30's. In this way, the 'ageing drinkers' share similarities to the 'middle aged desisters'.

The key difference emerges with the onset of multiple needs, which for 'ageing drinkers' generally emerged in middle age and was initiated by a single or multiple traumatic events based around the loss of someone close to them (see figure 6.5). All drank 'socially' before this turning point, but all noted 'giving in' to alcohol, referring to generally uncontrolled use. These accounts demonstrate how 'needs' can also develop from traumatic events later in life, as well as childhood. We may also understand these experiences as the onset of depression for which each turned to alcohol as a coping mechanism. As such, the sequencing of needs and capabilities is particularly relevant for these participants. The ongoing impact of trauma faced at a relatively late stage in life, without appropriate alternatives of social support led these participants to develop dependencies to alcohol.

For all four participants, their experience of homelessness is long term and long periods were spent in rough sleeping situations (see figure 6.5).

"We were hardened, hardened drinkers, dead simple. We baffled all the members of staff, we baffled everybody. However, we didn't destroy the place, we didn't do nothing."

(Liam. Static Trajectory)

In turn, they have all developed health issues related to long periods of rough sleeping and alcoholism.

"I took a heart attack and I ended up out cold and ended in hospital and they gave me a couple weeks to live if I didn't stop my drinking and, I'm not stopped my drinking but I'm still here."

(Jimmy. Static Trajectory)

As a result, the key needs this group present are related to health needs associated to old age and living in harsh conditions for many years. Further, all are of a

similar age and after the loss of the few people close to them don't seem to have any desire to change their behaviours. Even Joseph, who expressed more desire of all 'ageing drinkers' to reduce his intake demonstrated a lack of motivation:

"I'm not reaching too high because I can't be bothered to reach too high at the moment because I always said age didn't matter with me and its hitting there, in August I'm 63"

(Joseph. Positive Trajectory)

With their old age, many have very few social connections left either in their family or amongst homeless associates.

"But, hmm, in the past we've lost about 15/16 maybes 17 people. Like young kids when they've past, a, well it doesn't, well it does matter."

Interviewer: "Well, can we talk about that, it would affect me."

"Well it fucking affects me my friend! It fucking really affects me right. But, as some people think cos I'm like 59, it doesn't affect is, but it fucking really does affect is. "

(Arnie. Static Trajectory)

In turn, this group consistently discussed a strong sense of affiliation to street culture and to supporting other homeless individuals (Ravenhill, 2012). However, in doing so they also risked exploitation from homeless associates after entering their property (discussed further in section 7.3.3).

"I felt compassionate towards people who were on the street as well ... right and they took me for a mug."

(Jimmy. Static Trajectory)

Overall, this type did possess a relatively well developed capabilities which objectively would predict more successful trajectories. So why did they generally experience 'static' trajectories? Through a situational approach (section 3.5) we can suggest that repetition of action alternatives related to affective relief from traumatic experiences,

compounded by long term exposure to temptation from other homeless associates have intertwined with ageing processes accelerated by long term homelessness and alcoholism. The result is a reasonable lack of desire to pursue pro social roles, as realistically they have very few capabilities or opportunities to do so. Figure 6.6 now offers Jimmy's biography as an example of an 'ageing drinkers' life history.

Figure 6.6: A Case Study of Jimmy

Childhood
(0 – 13
years)

Jimmy grew up in the Glasgow tenements. Neither of his parents worked.
*"It was the f*cking Da's, never worked in their life, including my da, never worked in his life but he knew how to get pissed ... had 12 kids, my next door neighbour had 20."*

Adolescence
(13 – 18
years)

Jimmy attended school irregularly but also did informal work collecting scrap metal to make money for his family

Jimmy was spotted by his swimming coach at 14 and encouraged to pursue this. He was later given the opportunity to be paid to go to college to learn how to be a swimming teacher.

Young
Adulthood
(18 – 30)

Jimmy met his first wife in his late teens. At 19 he was given the opportunity to move to Durham to teach swimming. He moved with her and her two children. He had his first son at 22. They had a 5 bedroom house and a garden.

Jimmy's first son died at 3 years old after various health issues. At the time of his death Jimmy's wife was having an affair with his brother.

Middle Age
(30 – 45)

Jimmy split from his wife and began using alcohol heavily. Soon after he gave up his home and job and moved back to Glasgow.

In his early 30's Jimmy moved back to the North East to regain control of his alcohol issue. There he met his second wife. He moved in with her and continued to drink but to a much lesser extent.

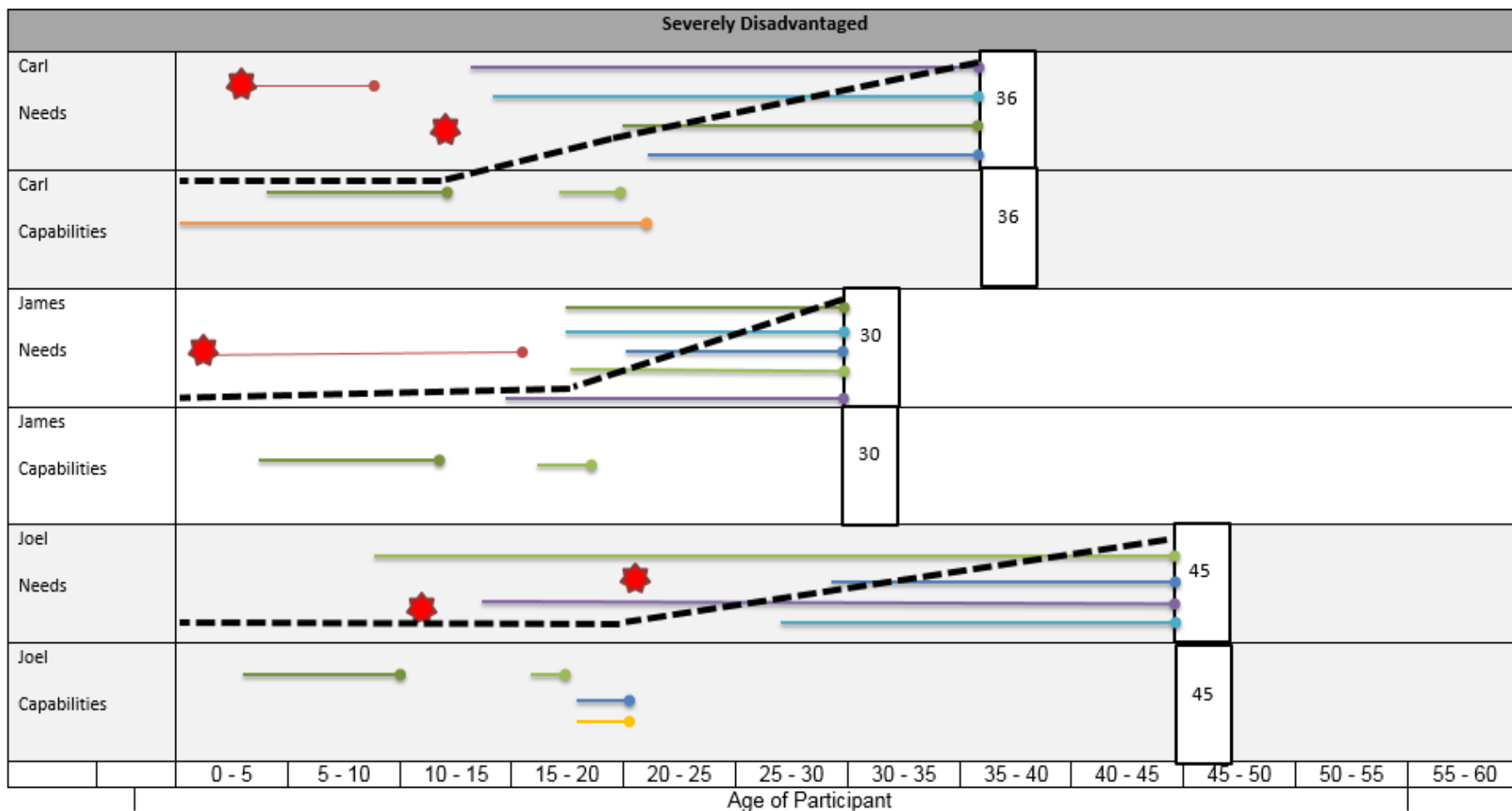
Late Middle
Age
(45 - 60)

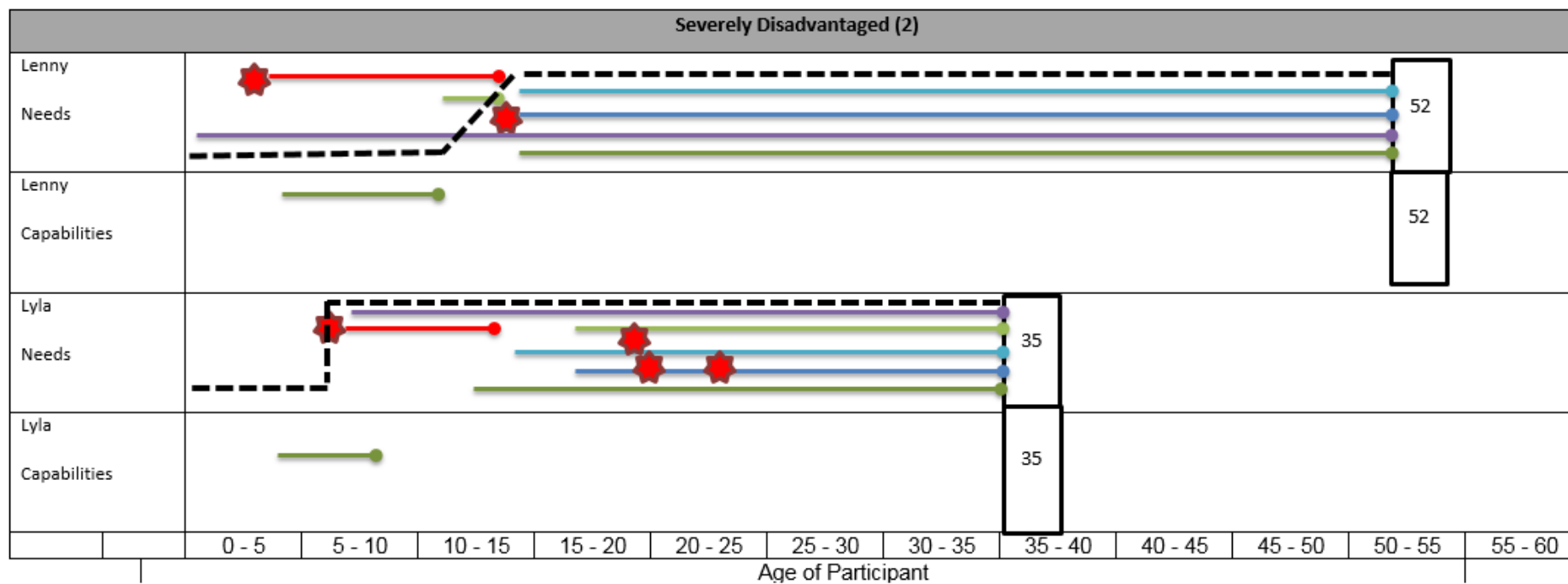
Jimmy's second wife also had an affair. At this point Jimmy's alcohol use increased rapidly. He took a train to Newcastle where he began rough sleeping at 45.


















Jimmy spent the next decade engaging in heavy alcohol use throughout the day, rough sleeping for long periods and spending time in homeless hostels. During this period Jimmy had at least 14 hostel placements with 10 evictions for violence to staff or residents

After being assaulted over Christmas Jimmy was accepted into a social housing tenancy in early 2014, through which he is supported by the Housing First service.

Figure 6.7: Temporal Mapping of Needs and Capabilities in the Life Histories: ‘Severely Disadvantaged’





Key of Relevant Participant Needs		Key of Relevant Participant Capabilities	
	Traumatic Experience and length of experience		Positive, Subjectively supportive Romantic Relationship
	Hostel/ Street Homelessness		Successful Tenancy Maintenance
	Substance Misuse		Unsuccessful Tenancy Maintenance
	Mental Health Issues		Period of SM Abstinence
	Offending		Period of Employment
	Street Culture		Regularly Attended School
	Age at Study Commencement		Achieved Qualifications
			Regular, subjectively positive familial contact
			Age at Study Commencement
Key of other Items			
		'Trend Line' Demonstrating the Balance of Needs and Capabilities	

6.3.4: 'Severely Disadvantaged'

Five participants were grouped together as experiencing 'severely disadvantaged' life histories: Carl, James, Lyla, Joel, and Lenny. Of course, the term 'severe and multiple disadvantage' can be applied to all these participants under the definition used by Fitzpatrick and Bramley (2015). In this study, those classified as 'severely disadvantaged' are more representative of Fitzpatrick and Bramley's 'SMD3' cluster, representing those with the most adverse life histories, most complex needs and least developed capabilities. In turn, this group are also closely representative of Fitzpatrick, Bramley and Johnsen's (2012) 'homelessness, hard drugs and high complexity' cluster.

Similarly to other 'types', these participants grew up in poverty, but all also faced a 'toxic' combination of severe abuse and neglect of various forms during childhood (Shonkoff et al., 2012). For four participants this was neglect and abuse was directly perpetrated by their parents. Carl and James reported severe neglect by their mothers, both of which had heroin addictions. Lenny and Lyla faced neglect by alcoholic parents as well as persistent physical abuse, and in Lyla's case, sexual abuse. Joel did not report abuse or neglect but was taken into social services as a child and experienced abuse while in juvenile detention.

"You know, I've been abused, me mam used to put me in bed with the person who abused me. She used to go downstairs and as she was drinking she used to know that I was getting raped upstairs"

(Lyla. Fluctuating Trajectory)

"Aye, well we never had a home, you know what I mean, never had no lowy, never had no food in the cupboards so, everything went on the drink, mother and stepfather ... Me and me stepfather didn't use to get on, he used to beat is all the time"

(Lenny. Static Trajectory)

“As soon as I was old enough to buy a bottle of cider, I’d go and buy a bottle of cider. And that was just to kill the pain of the way I was living, like me home life.”

(Lenny. Static Trajectory)

There is compelling evidence which demonstrates the link between childhood trauma and the use of ‘painkiller’ type drugs such as opioids (Maté, 2010). Wikström’s (2004) definition of temptation as the intersection of desire and opportunity can be applied here. The severe nature of these participants’ experiences, commonly perpetrated by parents who also engaged in substance use meant that both the desire to relieve emotional pain and the means (opportunity) by which to do so was also present. The damaging relationships between these individual’s and their parents is also likely to have hindered their ability to adhere to wider social norms. This is because our understanding and adherence to particular social values can be strongly associated to the moral guidance (or education) received during childhood (Wikström et al., 2012).

As a symptom of their home lives, all of these participants were either excluded from school or simply stopped attending, in turn all left with no qualifications, further limiting their contact with mainstream social norms (Van Oorschot & Finsveen, 2009; Wikström et al., 2012). James and Carl were entered onto apprenticeship schemes for young adults with such issues but neither completed these. The onset of multiple and complex needs occurred in mid – late adolescence for all and was compounded over many years through processes of social exclusion (Pleace, 1998; Gordon, 2000). Each of the issues is ‘multiple and complex’ in itself with poly substance use of emotional painkiller type drugs very common, various serious mental health issues, a range of offending behaviours and

commonly the most severe experiences of homelessness, with rough sleeping common.

“I was a raging smack head, I was a raging coke head, I was a raging alcoholic, and I was on 120ml of, this is prescribed this I’m gonna tell ya. 120ml of meth a day, 40ml of valium a day, 37.5 zopiclone [insomnia] and 45ml of mirtazapine [atypical antidepressant] a day, prescribed. And I was on 5 packets of heroin a day, 3 packets of coke a day and 3 bottles of tudor rose a day.”

(Lyla. Fluctuating Trajectory)

“I was injecting everything, amphetamine, cocaine, heroin, I was even injecting methadone but I lost all the arteries in me legs, you know, well, I died a few times. You know I had like six operations on me groins and me stomach and me legs, nearly lost me legs.”

(Joel. Fluctuating Trajectory)

As a result of their adverse were not able to develop any capabilities associated to a mainstream life, or to the priorities they outlined for the future. Instead, they lived almost all of their lives in a homeless situations. All noted deep immersion in homeless culture, which, in line with critiques of ‘treatment first’ models, acted to compound their already profound substance misuse issues and encourage offending behaviours related to street culture (Busch-Geertsema, 2013). Lyla (the only female in this group) also faced persistent traumatic incidents related to sexual and physical abuse by male partners and associates.

At the time of entering HF only Carl had maintained links with extended family but his relationship with his immediate parents is poor. Overall, these participants represent the most considerable challenges for the service in enabling ‘choice and control’ and subjectively favourable outcomes. Their needs are the most ‘multiple and complex’, are underpinned by severe trauma (see section 3.5.2). They also have the greatest degree of immersion in street culture activities and have lived

much of their lives in affective cycles of trauma, mental health issues, and substance misuse. Through a situational lens, it is not difficult to understand that this group face the greatest challenges of all participants. Each have spent the majority of their lives in local social networks in which behavioural norms are skewed towards transgressive behaviours (Rolfe, 2009; Ravenhill, 2012). Throughout, these participants were also trying to mitigate ongoing mental health issues related to past trauma. It is reasonable to understand that these personal and environmental factors, would lead to the development of capabilities deeply rooted in 'street culture' activities and affective relief provided by 'painkiller' type substance use (Buchanan, 2004). Each of which conflict with participants' personal priorities. As a result they are likely to require considerable multi-disciplinary support to overcome their needs, as offered in other HF implementations (see section 2.5). In turn, they have very few experiences on which to refer when making intertemporal choices towards longer term outcomes and very little positive support on which to draw outside of the immediate service. Figure 6.8 now offers Lyla's biography as an example of a 'severely disadvantaged' life history.

Figure 6.8: A Case Study of Lyla

Childhood (0 – 13 years)	Lyla was born and spent her early years in the West of England. Both of her parents were alcoholics.
	At 7, Lyla's mother took her to Newcastle. It was at this point where Lyla faced persistent sexual abuse by several men over around 6 years. Her mother was complicit in this abuse.
Adolescence (13 – 18 years)	Lyla's father died at age 13. Lyla began using drugs and alcohol around this time.
	Lyla, her siblings and her friends regularly engaged low level offending and substance use
Young Adulthood (18 – 30)	From her late teens and throughout her 20's Lyla engaged in extreme poly substance use, sex work, and was in a physically abusive relationship. She lived between various homeless situations, most often rough sleeping for long periods.
	Lyla's partner went to prison when she was 29. Soon after Lyla spent a short spell in prison. At this point she transitioned from heroin to methadone and reduced her drug use after falling pregnant. However, her child was taken by social services at birth.
Middle Age (30 – 35)	Lyla continued to engage in poly substance use, albeit to a lesser extent during her early 30's. She gained a Housing First tenancy after 8 months rough sleeping.

6.4: Typology vs. Trajectories in Housing First

Table 6.3: Participants' Life History 'Types' plotted against Outcome Trajectories

	'Positive' Trajectory	'Fluctuating' Trajectory	'Static' Trajectory
'Middle Aged Desisters'	3 (Bev, Lisa, Johnny)	0	0
'Young & Excluded'	0	2 (Linda, Gary)	0
'Ageing Drinkers'	1 (Joseph)	0	3 (Arnie, Johnny, Liam)
'Severely Disadvantaged'	0	4 (Carl, James, Lyla, Joel)	1 (Lenny)

As table 6.8 demonstrates, participants' life histories were highly predictive of particular outcomes trajectories. In summary, those with lowest needs and greatest range of capabilities were best able to progress towards subjectively desirable outcomes.

The 'Middle Aged Desisters' all experienced a positive trajectory. Each of these individuals had fewer and less severe needs to overcome, and had more capabilities on which to draw to support them in achieving outcomes in a range of domains.

The 'Young and Excluded' both experienced fluctuating trajectories. Their periods of 'relapse' were mainly caused when their control and anger management issues coincided with ongoing stressors associated with maintaining a tenancy. However, they did both experience substantial periods in which they were maintaining their tenancies and desisting from harmful behaviours, particularly around offending and substance use.

Three of the 'Ageing Drinkers' experienced a static trajectory, showing comparatively little hope that they would overcome their alcohol or health needs and experiencing loneliness, intersected with exploitative relationships with associates. Qualitative accounts demonstrate little clear desire to change behaviours of motivators for change. However, all of them maintained their tenancy. On the contrary, Joseph experienced a positive trajectory, while facing with considerable challenges. Interestingly, Joseph was the only of the 'ageing drinkers' not to experience a profound trauma in his life. In turn, he also possessed more capabilities useful for independent living, having longer experiences of tenancy sustainment, employment and describing better educational engagement. However, a unique combination of environmental factors were also important, as discussed in section 7.3.3.

The 'Severely Disadvantaged' most commonly experienced a fluctuating trajectory. They consistently demonstrated a desire to progress but had very few capabilities or experiences on which to draw to assist them in doing so. In turn, their deep immersion in 'street culture' activities and the profound trauma that underpinned their substance misuse and mental health issues meant that relapse was common and often severe in nature. Their capabilities for dealing with stress are commonly restricted to substance use (and they live very stressful lives, particularly living with trauma), their capabilities for making money are restricted to offending and street culture activities, their social networks are almost entirely based around other 'severely disadvantaged' associates having lived all their lives in homeless situations, high crime neighbourhoods or institutions⁴³. Lenny experienced a static trajectory and interestingly possessed some characteristics of an 'ageing drinker', particularly in being of an older age, and having more physical health issues than other severely disadvantaged participants.

⁴³ Each of these factors are considered further in section 7.3.4

6.5: Conclusion

This chapter began by outlining evidence relating to participants' perceived sense of choice in HF. This section 'set the scene' for the chapter, demonstrating that like other studies of choice in HF, participants perceived themselves to have high levels of choice over housing, support, and behaviour in HF. However, their capacity to utilise this perceived 'choice and control' to achieve recovery and desistance orientated outcomes differed significantly, as demonstrated by their differential trajectories.

An important finding in this section was that, when determining their level of choice in HF, participants consistently compared to previous experiences in order to understand how much choice they had in HF. This process of drawing up past experiences to inform present decisions is central to the theoretical understanding of decision making laid out in Chapter 3.

The same theoretical understanding highlights how past experiences lead to the development of personal needs, capabilities and preferences. These personal factors are clearly very important in determining participants' capacity for utilising the mechanism of choice to reach subjectively desirable recovery and desistance orientated outcomes. Exploring participants' biographies through biographical narrative interviews proved to be a very useful means of understanding the balance of relevant 'needs' and 'capabilities' for each.

The balance of 'needs' and 'capabilities' in the lives of participants illuminated that although experiences were broadly similar, considerable variation in the extent and severity of needs, and the extent and mastery of capabilities. In turn, each of the four 'types' of life histories were highly predictive of particular outcome trajectories in HF. These findings highlight the importance of situating participants' recovery and desistance processes within the context of their life history. They also demonstrate the importance of biographical factors in determining the differential

challenges participants face in HF. Further illuminating the need for biographical accounts to be taken seriously in HF.

However, it is also useful to explore these processes in the physical and social context in which they take place. As Chapter 7 highlights, the needs and capabilities in participants' personal histories were largely mediated by environmental factors which favoured those participants with less 'multiple and complex' needs and more capabilities, particularly around positive, supportive social relationships. In turn, the challenges presented by each different 'type' were unevenly met by the particular model of housing and support provided in this implementation of HF. As the single case manager model is particularly common across Europe (Busch-Geertsema 2013) (section 2.6.2), and the UK in particular (Pleace, 2016) (section 2.8) these findings also have wider importance.

7: Environmental Analysis of the Capacity for ‘Choice and Control’

7.1: Introduction

This chapter explores *the environmental factors that affect clients’ ability to utilise ‘choice and control’ to achieve desirable outcomes.*

The previous chapter explored variations in the balance of relevant ‘needs’ and ‘capabilities’ in the life histories of participants, before outlining a typology, predictive of participants’ outcome trajectories. In the process, the chapter highlighted the importance of participants’ pasts in determining their ability to exert choice and control over their present and future. However, personal factors alone do not tell the whole story of why some participants did better than others. A situational approach allows the important role of environmental factors to be identified.

Factors related to wider structures, institutions, and local social networks affected the trajectories of all participants by determining the ‘norms’, ‘resources’ and ‘opportunities’ available to them (see figure 3.1 and section 3.5.2). Section 7.2, highlights the common factors which affected all participants in relation to three key areas which emerged in initial coding; housing, support, and local social networks. This section sets the scene for section 7.3, which highlights the often nuanced differences in participants’ capacity for choice and control, defined in terms of their situational capacity to direct their trajectory towards subjectively desirable outcomes.

The typology offered in section 6.3 also predicted the impact of environmental factors on participants’ capacity for choice and control. This is because environmental factors consistently mediated the impact of participants’ life histories on their trajectories. Participants’ ‘needs’ and ‘capabilities’ (as well as the

'preferences' these represented) interacted with 'norms' and 'opportunities' in their environmental setting to produce different outcomes.

As such, in section 7.3 the environmental facilitators and barriers of choice and control are largely structured according the typology outlined in section 6.3. For each 'type', the common factors are highlighted within key themes of housing, treatment and support, local social networks, and wider service stakeholders. Throughout, links are made back 'HF', 'choice', and 'recovery and desistance' literature in order to situate the experiences of these participants in the wider body of knowledge on choice, and success for MEH adults. First, section 7.2 outlines the environmental factors which influenced the capacity for choice and control (and therefore the outcome trajectories) across all participants.

7.2: Commonalities in Environmental Factors

Before exploring the differences between participants' experiences, it is first useful to outline the common environmental factors that affected participants' capacity to enact control over their trajectories.

7.2.1: Common factors influencing choice over access to housing

Housing Location

All participants were offered some degree of choice over housing location. The service asked participants which area they would like to live in and allowed them to view the property. However, the efficacy of these mechanisms for increasing the options available to participants was mitigated by their housing situation at the time of choosing. At this time, all participants were in homeless situations and almost all had a negative perception (see section 6.2.2). Therefore, the 'action alternative' of remaining in this situation was less favourable than any type of independent housing. As a result, participants engaged in a deliberative choice process, but only to a limited extent.

However, this was not the only factor that influenced participants' capacity for choice and control over housing. A combination of other factors were also relevant. These factors generally emanated from the service's decision to source housing solely from the PRS.

Sourcing from the PRS

The service almost exclusively sourced housing from the PRS, with one exception; Jimmy, who was placed in social housing after a violent assault and concerns over his physical health and social care needs were raised by police. As a result, Jimmy was placed in social housing, but received support from the HF service due to his 'multiple and complex' needs and history of exclusion.

As noted in section 6.2.2, the most desirable housing tenure for most clients was social housing, rather than PRS. However, participants were not offered the opportunity to access social housing. The service utilised PRS accommodation for two reasons. Firstly, because many had high levels of rent arrears from previous placements in social tenancies which excluded them from accessing this form of housing.

The second reason relates to the wider trend towards private rented accommodation, both for those who are homeless and in the HF model. In the UK, this trend has become especially prominent since the Localism Act (2011) allowed local authorities to discharge their statutory duty to homeless households by placing them in the PRS. With reference to HF, the principle of 'independent, scattered site housing' was originally delivered by placing individuals in PRS tenancies (Tsemberis, 2010). However, the North American implementations from which best practice often emerges operated in a context where social housing was not available on anywhere near the scale required. In many European countries, such as Denmark, where social housing is an available resource, this tenure has been utilised in HF implementations (Benjaminsen et al., 2017). Although, Benjaminsen et

al. (2017) did still highlight significant challenges in accessing affordable housing. In Newcastle, the decision to source all accommodation from the PRS presented a range of barriers to participants 'choice and control' over housing.

Limited 'purchasing power'

In recent years, evictions from the PRS have become the most common cause of homelessness in England (Fitzpatrick et al., 2017). Further, the most recent homeless monitor for England has identified that one in two local authorities in England find it very difficult to place homeless individuals in the PRS. In this study, a number of factors converged to limit participants' choice and control over housing by restricting their access to a wider range of PRS properties. In turn, the resources and opportunities available for participants to establish a foundation for greater stability and control over their lives and to pursue other desirable outcomes was also limited.

On a structural level, Local Housing Allowance (LHA) rates limited the range of properties available to the service, and therefore clients. LHA rates moved from 50th to 30th percentile of local market rents in 2012, reducing the financial resources available to clients when accessing the PRS market, and therefore, the available housing options (Gibb et al., 2014). In essence, this meant that HF clients could only access, at most, 30% of PRS properties available unless they were willing and able to pay a 'top up' on their housing benefit each month. Clarke et al's (2008) conflict between client choice and public service delivery plays out here. The choice of clients would clearly be maximised by increasing LHA rates, allowing access to a broader range of properties. However, as clients housing is being paid through public finances, their resources and options are limited to those which are undesirable. Due to the complex needs of these clients, and the HF principle of

'independent' housing (see section 2.7.1), it was not deemed feasible to place clients in shared tenancies.

The range of needs clients presented, as well as the operational capacity of the publicly funded HF service to source appropriate properties diminished choice for clients further. Spurr (2017) identified that private landlords were generally unwilling to let to housing benefit claimants. For a HF service, these barriers are heightened as the service is approaching private landlords with the implicit recognition that these claimants have also lived largely 'chaotic' lifestyles for a number of years. As outlined in sections 3.5.2 and 3.5.3, the transgressive preferences of MEH adults represent an undesirable and stigmatised identity, which has contributed to their social exclusion and exclusion from 'treatment first' accommodation projects (Busch-Geertsema, 2013; Ridgway & Zippel, 1990; Pleace, 1998). When accessing PRS, this process of exclusion arguably continues as these same issues have contributed to participants' exclusion from many PRS properties.

Vitally, the HF service was able to pay each participants' deposit to enable the opportunity to access the sector. Nevertheless, rather than being able to freely choose as 'consumers', participants were in fact actively 'sold' to landlords. As the North East has the most affordable private rental market in the UK, there is likely to be an exacerbation of these issues for other HF implementations across England (ONS, 2016b).

As a result, of these factors, the range of tenancies available to participants was generally limited to those in more socio-economically deprived areas. As such, although choice was available in theory, the combination of reduced LHA rates and of utilising the PRS meant that participants' capacity to actually control where they lived was restricted. As the 'choice' of housing is intertemporal in nature, the

restricted availability of housing also had longer lasting effects for participants' trajectories, as explained in later sections.

Over time, the transgressive behaviours of some clients became a more prominent factor determining the service's capacity to source housing from the PRS. A number of clients caused damage to flats as well as neighbourhood disturbances. As one of the service managers notes, the structural barriers the service faced in sourcing properties exacerbated the impact of damage to tenancies:

"We went through a period where we were struggling with, they were the only landlord who seemed to have properties available so they got a cluster of clients and about 3 or 4 tenancies started to go wrong at the same time. So things are a little bit strained because obviously we don't cover the cost of everything."

(Service Manager)

Because of various instances of damage, the service's relationship with landlords became strained. Eventually leading to two landlords who provided numerous properties deciding that they would not take on any new tenancies for an undefined period of time.

"The landlords we had like [landlord name], she had a heart of gold. [property management firm] were very good and I can see why they got to their wits end with clients, I really can."

(Service Manager)

These transgressive preferences clearly conflicted with the landlord's preferences for more 'mature' actors, shaped by socialisation (Freese, 2009). These preferences are unsurprising, as even those landlords with more altruistic motivations cannot be expected to be content with damage to their properties. However, the effect was to limit the resources and opportunities available to other HF clients by limiting the range of properties available to them.

Common factors influencing control over housing

A number of factors influenced participants' capacity for control over housing, after they had accessed it. The principles of HF are largely designed to re-balance power relations between clients and the service supporting them (Tsemberis et al., 2004). In particular, the separation between housing and support offers clients the 'right to refuse' support and maintain housing (see section 2.7.4). However, neoliberal service provision involves a wide range of stakeholders (landlords, employers, education providers), outside the immediate service providing HF. As discussed in relationship to 'opportunities and resources' in section 3.5.3, these stakeholders also represent gatekeepers of wider social inclusion (Bradshaw et al., 2007; Quilgars & Pleace, 2016) When sourcing housing through PRS, the power relationship between HF clients and their private landlord becomes particularly important.

The first factor that restricted participants' capacity for choice and control was the use of probationary tenancies. All participants who entered the PRS were initially offered a 3 month probationary tenancy. Probationary tenancies were a necessary concession to landlords to mitigate the perceived risk of renting to this group and did enable access to PRS properties. However, it was also evidence of an imbalance in the power relations between tenant and landlord, in favour of the landlord. Keat, Whiteley et al.'s (1994) concept of taboo as a means of maintaining authority is a useful explanatory tool here (see section 2.7.4). The taboo associated to these clients justifies a power imbalance in favour of landlord, due to perceived risk. This caused apprehension amongst some participants, as highlighted by Gary:

"It's just them ending the tenancy, I try not to worry about it but it seems to come up in my mind a lot ... It's just generally because I know that they have the power at the end of tenancy to say right, you have been a good tenant and stuff like that but we're looking for someone else to move in."

(Gary. Fluctuating Trajectory)

Beyond the initial stages of the tenancy, repairs were the medium through which most interactions with the landlord took place. It was evident that there was a clear power imbalance between landlords and participants, with participants having little possibility of influencing a landlord to carry out a repair. In this regard, their 'choice and control' over housing was limited. For example, Bev's case manager described an issue with plaster falling off her walls:

"And she started getting pretty shitty on the phone. I says there's big cracks it's just going to fall off, it needs to be lined then papered. It doesn't, it's the clients responsibility. Well she can't afford it! D'you know what I mean! This is an absolute joke, you're the landlord, please get it sorted! It just makes the rest of the house, the home! Look a mess."

(Case Manager)

As noted by Clapham (2011) the physical structure of accommodation can constrain meaning and purpose. In this study, issues with the physical quality of housing caused stress for a number of participants and limited the subjective benefits of independent housing. However, due to damage done by other clients in other properties owned by that landlord it was also difficult for case managers to effectively advocate for repairs. In addition, the relatively low number of landlords each of whom rent a number of properties restricts the services capacity to challenge these landlords.

But yeah, it is very difficult because the whole idea, and the whole thing that was sold to the landlords is, should there be a problem, we'll step in, and it doesn't matter at what point that is.

(Service Manager)

These findings represent important considerations for any HF service that utilises market based PRS accommodation, as discussed further in section 8.4.2.

7.2.2: Institutional and Professional Support

Case Managers and Service Managers

As highlighted in section 6.2.3, decisions over the focus of support were guided through collaboration with case managers, and support was generally in keeping with participants' priorities. Case managers sought to inform participants by offering their opinion but the choice was left to participants. The two key types of information which inform choices are memories and environmental cues (Wikström, 2004; 2014) (section 3.5.2). Local social networks are particularly important as they determine the nature of most environmental cues. More detailed discussion of local social networks can be found in 3.5.2. At this point, it is most relevant to note that these networks are defined by closeness in terms of "*cohesiveness, physical location, similarity, and frequency of contact*" (Rolfe, 2009: 434). Developing 'closeness' between case manager and client is essential to inform choices. Case managers recognised the importance of developing closeness through trusting relationships and sought to develop these.

"It's just a long, hard, scary process for them and our role is to encourage them and support them and make it as easy as possible. Not fill them with bullshit, and tell them exactly how it is ... They've been let down that much in their lives. So my massive thing is I'm always honest with clients, I'll never lie to them, even if its bad news, because the longer you leave it the worse it gets."

(Case Manager)

"The first set is my set of goals as a support worker, being honest, you know, you tell me about yourself ... I cannot help but create a checklist in my head of all the things I want to help you with, I'm not saying that's a complete list, I'm not saying it's a perfect list ... But I do have a list of basic needs around what someone tells me. And that's around physical health, it's around offending, it's around family relationships, mental health, drug and alcohol problems."

(Case Manager)

On a wider level, the service also offered financial support to participants after issues arose with sanctions, arrears, or property damage. In these cases, the service offered financial 'bail outs', and helped participants clean their flats to prevent eviction and further exclusion. This type of support arguably stretches the limits of the principle of 'open ended' support, which generally only refers to continuing to work with clients after eviction, rather than actively preventing eviction itself (see section 2.7.3). In turn, the approach may be understood as an innovative approach by preventing further exclusion and the consequences homelessness brings (Pleace, 1998) (see section 3.5.3). However, these 'bail outs' did lead to frustration amongst many HF case managers. During the final wave of interviews with case managers, these frustrations were expressed as a desire for greater conditionality in the HF model.

'Creeping Conditionality'

A small number of case managers expressed concerns around readiness and open ended support during the first wave of interviews. By the final wave, these concerns had become prominent in the accounts of all case managers. Qualitative accounts revealed that a perceived lack of progress towards favourable outcomes, and experiences of 'bailing out' led some to question the degree of autonomy offered to clients. In turn, some noted a desire for greater conditions particularly around 'readiness', and the point at which an individual case is 'closed'. As two case managers noted during periods of disengagement:

"I think there needs to be something signed which says you agree to do this, you agree to pay your bills. I don't know how we stand with that, but I think there needs to be something signed to say you must engage."

(Case Manager)

“I just can’t understand why we don’t have a cut-off point, we need that, we need a structured process which has to be flexible”

(Case Manager)

Other case managers were able to reflect further on these feelings of frustration:

“I think its frustration a lot of the time. You hope you’re going to get a message across to your client that the way they’re behaving and acting is having an impact on their quality of life, them losing their tenancy, and them not acting on it.”

(Case Manager)

“It festers and it becomes toxic and it becomes difficult to keep focus on the client because you’re frustrated, you’re fed up, and actually you have no real value.”

(Case Manager)

These preferences for greater conditions may also be explained by many years working under a ‘treatment first’ philosophy (see section 2.2). Although this philosophy has been shown to exclude those with ‘multiple and complex’ needs (Culhane & Merteaux, 2008) (see section 2.3), it does offer a number of ‘tools’ for encouraging compliance. In a ‘treatment first’ philosophy, case managers can utilise the ‘carrot’ of housing as an enticement to behave in ways they deem in keeping with progress, and the ‘stick’ of eviction if clients didn’t behave in these ways. Through principles of ‘choice and control’, ‘open ended support’ and the ‘separation of housing and treatment’, HF rebalances the power relationship between client and service, but also removes both the ‘carrot’ and ‘stick’. This leaves case managers with encouragement and persuasion as a means of supporting participants processes of change. Proponents of the HF model argue these less paternalistic approaches are more successful in facilitating positive change (Greenwood et al., 2005; Padgett et al., 2006). However, without sufficient training, supervision and

encouragement there does seem to be an inherent risk that conditions may 'creep' in, limiting clients' capacity to control the direction of their support and process of recovery or desistance.

"Quite a lot of them come from accommodation backgrounds ... But some staff had to be reminded of what their job was, quite a lot to be frank with you. Because they'd say ah, he's f**ked is off and I'm not going back there. It's like, no, he's having a bad day or a bad week, you need to keep plugging away."

(Service Manager)

There were some concerns about insufficient formal supervision amongst case managers that may have contributed to these issues. However, others reported that service managers consistently re-affirmed the reasoning behind a HF philosophy.

"But something I think people forget is, the louder someone shouts, the more trouble they cost us, the more they cost us in fixed doors, the more fights they start, it just correlates with the more shit they're dealing with and they've been through in the past. There's a bit of a culture of blaming clients, cutting people off. They are the person who smashed that window, no doubt. But we're in the business of understanding why people smash windows."

(Service Manager)

"We want people to say all the right things, we want people to want the things we want for them. That's what we want, and I think one of the great things that [service manager] put forward was; whatever it looks like, and whatever it sounds like, you've got to go with the service user. Because at the end of the day, you can't tell me what's right for me. I don't even know what's right for me."

(Case Manager)

These quotes demonstrate both the frustrating and challenging nature of clients' behaviours, but also the importance of a HF philosophy in encouraging

understanding of these behaviours rather than excluding. In turn, they give further support to arguments that the client led approach in HF is the most humane means of supporting MEH adults (Padgett et al., 2006).

Service Remit

Participants' capacity for choice was also affected by the service remit and model of support. Understandably, the service's primary aim was to ensure housing stability. As a result, the service largely focused on housing retention.

This was influenced by the combination of a few factors. Firstly, housing retention is key to HF and to the achievement of other outcomes. As a result, these tasks rightly took priority. Importantly, these tasks were also in line with case managers' capabilities as professionals in the homelessness sector.

However, case managers were also simply responding to the choices of participants who commonly directed them to these tasks. These tasks took priority, but also took long periods of time. It is important to appreciate that case managers typically only had up to an hour with each participant and most housing retention tasks involved waiting on hold for long periods, leaving little time for other tasks. They commonly involved the participant explaining the issue, the case manager familiarising themselves with that issue, negotiating calls to relevant agencies (including waiting on hold), before agreeing a course of action with participants.

Importantly, like most other English implementations of HF (Bretherton & Pleace, 2015) (see section 2.8), the service was structured to 'signpost' to other services to enable wider support, allowing case managers to focus on tenancy sustainment tasks. However, participants' capacity to access other services varied. To some extent, this resulted from participants' own inaction in missing appointments:

“Why didn’t you turn up? Basically it was because they couldn’t be bothered. They need to take a bit of ownership themselves. We have to deal with it, we’re independent living now, you have to do it as well.”

(Case Manager)

However, more often barriers emerged from the institutions providing support. The extent to which participants were able to access other support did vary considerably. This variability was largely related to the extent and severity of participants’ needs and is discussed throughout section 7.3, with reference to each life history ‘type’.

7.2.3: Local Social Networks

Associates / Friends

In HF and recovery literature, social networks developed with individuals who share similar needs and transgressive behavioural preferences are understood as fundamental barriers to recovery (Volk et al, 2015; Dingle et al., 2016). This is one reason why HF (and supportive housing more generally) situates clients recovery away from congregate housing common in ‘treatment first’ models, instead housing them in ‘the community’ (Carling, 1995; Goodman et al., 1991; Lamb, 1993; Tsemberis, 2010). In this study, all but one participant noted that associates they had developed in a homeless setting were overwhelming negative. For many their first priority was separating from these individuals (see section 5.2.1). Nevertheless, almost all participants had their trajectories negatively influenced by these associates. However, the severity of the impact on participants’ trajectories did vary considerably. Differences emerged around whether participants were able to recognise this negative influence, and separate from it.

A number of factors influenced participants’ capacity to do so, each of which are noted in this section but discussed in more detail with reference to each ‘type’ of

participants. Firstly, the location of housing in terms of its geographical proximity to homeless hostels and high-rise social housing. Secondly, the extent of participants immersion in 'street culture' (largely influenced by the length of time they spent in a homeless setting prior to HF). Thirdly, the extent to which participants substance misuse issues relied on interaction with associates. As highlighted in section 6.3.3, poly use of illicit drugs was particularly common among the 'severely disadvantaged' cluster. As a result, this group had to visit dealers more often, and faced higher costs to maintain their substance dependencies, leading them to rely on familiar capabilities of making money (e.g. 'begging'/'tapping')⁴⁴.

7.3: Differences in Environmental Factors by 'Type'

As explained in section 7.2, a number of factors related to housing, institutional and professional support, and interpersonal networks affected all participants' capacity for 'choice and control'. However, it was also possible to identify differences in the ways that these factors affected each 'type' of participant. In this section, the typology developed in Chapter 6 is used to demonstrate the differences as to how far, and in which ways, these environmental factors influenced participants. Specifically, it demonstrates that those participants with more challenging and complex life histories tend to face greater environmental barriers to exercising choice and control, and achieving positive trajectories.

7.3.1: 'Middle Aged Desisters'

The 'middle aged desisters' experienced the least number of environmental barriers to exercising choice and control. In turn, they faced the greatest number of facilitative factors that enabled them to make choices in line with their own personal priorities. Subsequently, these participants all experienced positive trajectories during their time in HF.

⁴⁴ See Appendix B.2.1 for further discussion of begging as a 'capability'.

Housing

Like other participants, the extent to which ‘middle aged desisters’ had choice and control over their housing was broadly restricted by structural factors such as LHA rates and the market based nature of the PRS. However, their situational capacity for choice was still the most favourable of all ‘types’.

All three participants moved into housing located in areas further away from the city’s hostels and homeless services. In turn, none of these participants were housed in an area of high density social housing, which for other participants increased contact with formerly homeless associates.

Even so, Bev and Johnny were initially housed in subjectively less desirable areas. However, each was able to negotiate moves to more desirable areas. In line with other participants (see section 6.2.2), each had taken the first property offered to them as a means of escaping their homeless situation.

“So I just thought I’ll take the best I can get you know. So the one in [area close to homeless services] was a definite no, no. Cut a long story short, err, I made a mistake of, my biggest downfall is helping people, and I tried to put this lad up, who was a friend, unknown to me his girlfriend was gonna boot out of jail. She was kipping outside me door when a was at me mams and I said nar, right I want to get rid of the flat, I’m not having that sh*t.”

(Johnny. Positive Trajectory)

As highlighted in the above quote, Johnny made a familiar mistake of allowing a homeless associate stay at his new flat. However, he quickly identified that this had been a mistake and instead sought to move elsewhere. Johnny initially made a less deliberative choice informed by ‘thin rationality’ of wanting to separate from a homeless situation (Elster, 1996; Somerville & Bengtsson, 2002). However, the information acquired by moving to this area and inviting an associate in enabled

him to make a more informed decision. In turn, Johnny possessed the motivation and capabilities (see section 6.3.1 and Appendix B.2.2) to go back to the HF service and seek a move to a more desirable area further away from homeless associates.

“I’ve got no plan of still losing me flat and ballsing it up and then going back over, whereas some of them have, they just seem to be going from year to year, round in a circle, and I’ve done that myself but I’m not going back over there.”

“If I wanted to keep meself to meself some of these places, knowing all these places you cannit. They’re at your door, they’re on your case, they’re trying to burgle your house. I cannit live like that.”

(Johnny. Positive Trajectory)

For each of the three ‘middle aged desisters’, the property they spent the majority of their time in was in a subjectively desirable location. Each participant did note some issues with some aspects of the material quality of the housing. For instance, Bev’s landlord consistently failed to repair issues with plaster on the walls and sockets which weren’t working. However, Bev and other ‘middle aged desisters’ were able to draw on practical support from family to resolve these issues, as discussed further in reference to their *‘local social networks’*.

Living in these more desirable locations led to other factors that promoted participants situational capacity for choice. Firstly, the absence of homeless associates who had previously offered temptation to engage in substance use (Wikström, 2004). Geographical separation from these associates also separated these participants from the transgressive behavioural norms and specific motivators these individuals brought (Dingle et al., 2015; Kirk, 2012). As a result, ‘middle aged desisters’ could make choices which aligned with deliberative priorities associated to recovery, rather than habitual choices associated to affective relief from stressors. This represents an important transition away from homeless situations where for participants and homeless individuals more generally choices are

generally made affectively and habitually, further compounding their 'needs' (Dwyer et al., 2014; Helfrich & Chan, 2013).

However, as highlighted by Johnsen (2014), separating from these networks without alternative social contact can lead to isolation and loneliness. Importantly, in their new communities, each of these participants reported good relationships with neighbours, to the point that they received practical support that also enabled a greater sense of ontological security (Clapham, 2010).

"Lovely quiet location, lovely neighbours. Doesn't matter what I want they'll help, they even said before I had the bairn if anything happens and you need him taking to the hospital or anything like that then we'll help ya."

(Lisa. Positive Trajectory)

Lisa had been considering moving closer to her mother in the area in which she grew up. However, with the support from the mother she was able to make a deliberative choice, based on past experience to stay in her current location.

"I changed my mind again last weekend when I had that heart to heart with me mam. I wanted to be back next to her again. But then me mam was like, it's not that I divn't want you next to is or anything. It's that everyone over here knows your past, they're vindictive tw*ts. She says that's the only reason I don't want you coming back over here, she says cos I divn't want ya getting tortured. It's like nee one knows is over here, nee one knows me past."

(Lisa. Positive Trajectory)

However, Johnny did still face some initial challenges in building these relationships, after a previous HF tenant had caused noise complaints in the property:

"Fortunately the street where I live, you can hear a pin drop. And the neighbours aswell, even if I go away I always used to worry about my flat. My neighbour downstairs had a moan and groan when I moved in and me

brother had a word with a ... she was just on her guard cos they'd had the police there, the door had been booted in, ya know what I mean.

Now the two neighbours ... every time I see them it's 'ah, you alright Johnny?'. He give is a lift up into town. They've said to is if you ever need a run up to your mam's in an emergency and I'm thinking, you never get neighbours like this anymore. So it's nice."

(Johnny. Positive Trajectory)

As a result, Johnny moved into this property with a degree of stigma immediately attached. However, with the support of his brother, he was able to alleviate his neighbour's concerns and build positive relationships with them. In turn, Johnny developed his local social networks and resources with which to pursue his own personal priority of 'being there' for his immediate family. For these participants, their tenancies offered the foundation intended in the HF model (Tsemberis, 2010, see section 2.7.1), in turn, providing these participants with a 'place to be' (King, 2003) and the opportunity to pursue their own subjective notion of recovery.

Local Social Networks

Local social networks have emerged as a consistent theme throughout this thesis. They form the most prominent set of environmental influences on participants' choices (see section 3.5.3). In turn, their orientation played a key role in directing participants towards choices, which compounded needs or developed capabilities.

Each 'middle aged desisters' experienced challenges associated to homeless associates, but these were limited. Johnny's experience has already been highlighted and for Lisa, the significant motivator and responsibility of having a new child limited her desire for interaction with homeless associates. Instead, Lisa was able to find significant professional support from her child social worker, child

support volunteers, the local 'Sure Start' centre, and her drug and alcohol worker, in addition to the support she received from her mother and brother. In this way, although Lisa's new child represented a significant challenge, but also one which drastically shifted her social networks towards those which were associated with mainstream social norms.

"Aye. I went to [drug treatment centre] yesterday, cos I missed the chemist again on Friday. I was f*cking divvin man, I was gonna try to dee hardcore (heroin)! So I ended up gannin to [drug treatment centre] yesterday and breaking down. "

(Lisa. Positive Trajectory)

This quote demonstrates a 'critical juncture' in Lisa's trajectory in which she risked relapse into heroin use and the other consequences this may have brought (e.g. risk of losing her child) (Collier & Collier, 1991). Lisa was able to select the action alternative of accessing professional support. However, this was only possible because Lisa had the opportunity to access support and treatment, and was motivated to utilise this opportunity. As such, Lisa was able to utilise the emotional and material resources provided by her professional support networks to support her positive trajectory and avoid relapse.

For Bev, the relationship she had established in a homeless setting represented a significant barrier to pursuing her long term priority of developing links with her children. Bev was able to end this relationship with support from her family. This 'choice' is the basis for a situational vignette in Appendix B.3.2.

Two key factors limited the negative influence of 'associates'. Firstly, the limited immersion of these participants in 'street culture' while homeless (see section 6.3.1). This finding supports findings in the Canadian 'Chez Soi' implementation, which suggested that immersion in street culture was associated to negative outcomes in HF (Volk et al., 2015). Secondly, moving to housing located

further away from the main cluster of homeless services and high-density social housing.

As well as separating from social networks that had acted to compound substance use in homeless settings, each 'middle aged desister' had the benefit of drawing on positive, supportive relationships with family. Similar to the findings of England Kennedy and Horton (2011) these familial networks offered practical and emotional resources for participants to draw upon when making choices, in turn encouraging positive trajectories. Practical support came in various forms including carrying out repairs, offering financial support, and childcare. All 'middle aged desisters' were able to draw on family to come in and help them conduct repairs, in turn improving the quality of their housing. They also received appliances and furniture as gifts.

"Aye, I've got a new cooker and I've just got a whole load of stuff off me dad for Christmas. George Foreman and all that, knives and things. So I've got all me stuff back so I've been experimenting a bit, well you know with the time I've had to myself, with me cooking. But I'm going back in cheffing aswell."

(Johnny. Positive Trajectory)

"Me dad, he drops it off and that when I go down. He was here yesterday actually fixing the washer."

(Bev. Positive Trajectory)

Emotional support came in the form of moral encouragement, therapeutic conversations, and an alternative social network to associates. Some examples of this are highlighted earlier, for example Lisa's chat with her mother over her prospective move. In turn, all three participants began socialising with their siblings, for Johnny this led to developing friendships with his brother's friends.

Positive social relationships are key protective factors in recovery and desistance processes (see section 2.7.1). This closer analysis of the ways in which these social connections influenced participants' choices highlight some of the nuanced ways in which their relationships can enable more positive trajectories. In particular, the combination of participants' local social networks, and their housing location meant that they benefited from 'enabling environments' in which the opportunities, resources, and norms available to them were all aligned with long term recovery orientated priorities (Rhodes, 2009) (see section 2.7.2).

Service Remit

'Middle aged desisters' also benefited from a service model which was adequate for their needs. In other words, the service's focus on housing retention and support fitted well with the needs and capabilities of these participants.

Comparatively low needs meant that these participants relied less on non-housing services (substance misuse, community mental health) to begin moving towards longer term outcomes. In turn, the lower incidence of violent behaviour underpinned by traumatic experiences teamed with greater experience of capabilities relevant to engaging with mainstream services can be understood as allowing participants to present in a more civilised manner⁴⁵. In essence, their issues were less severe and resulted in less 'chaotic' behaviours meaning they could not be excluded under terms of health and safety or dual diagnosis (Priester et al., 2016)⁴⁶.

Wider Service Stakeholders

⁴⁵ See sections 3.5.2 and 3.5.3 for discussion of preferences for 'civilised' behaviours as a basis of social inclusion and exclusion.

⁴⁶ See section 3.5.3 for discussion of how MEH adults are excluded from multi-disciplinary support.

Outside of the HF service and the related services which were 'signposted' into, 'middle aged desisters' did face some specific challenges related to wider service stakeholders; specifically from government departments.

All three participants faced statutory conditions related to personal progress. Both Bev and Lisa faced social work assessments around retaining access to children. Johnny faced conditions related to seeking employment and receiving JSA. However, these conditions were in line with participants own outcome priorities and for both Bev and Lisa these conditions came with considerable support. As a result, each successfully abided by these conditions. On the other hand, Johnny's experience of welfare conditionality can be seen as more punitive. Johnny was sanctioned for missing an appointment which he affirms he rang to re arrange:

"Aye I had a sanction at the start for 3 month. It was supposed to be 2 weeks and then it went to 4 weeks and then it was 8 weeks."

(Johnny. Positive Trajectory)

Importantly, Johnny was 'bailed out' by the HF service but over this period his financial resources with which to maintain his flat or even to pay food were restricted. Without financial support from the HF service, Johnny would have had little choice but to accrue rent arrears, potentially leading to eviction and increased emotional stress. Even after receiving financial support, Johnny still faces the consequences of this period as he is in debt on his utility meter.

"Big impact! I ran into like me meter, me gas meters still in debt now. [Service Managers] went over a while ago and paid that debt off ... which was a big help."

(Johnny. Positive Trajectory)

Importantly, Johnny was able exercise self-control and behave in a 'civilised' manner, even amidst his anger at, in his view, being unfairly sanctioned.

“Interviewer: So when you went in full of hell were you able to like, keep your emotions in check?

Ah aye, you’ve got to don’t ya, cos that’s what they want, you gan in like that they’ve got another excuse to sanction you”

(Johnny. Positive Trajectory)

As a result, Johnny was able to negotiate a change of Jobcentre advisor to one which he perceives as being much fairer. Throughout these experiences, ‘middle aged desisters’ were able to conform to the behavioural norms placed on them by statutory bodies which preference ‘maturity’ and ‘civility’ (Dwyer, 2010; Gintis, 2000) (see section 3.5.2). In doing so, they largely avoided (or in Johnny’s case mitigated) the negative impact of material and non-material sanction (Elster, 2009). Of all participants, ‘middle aged desisters’ were amongst those who had the greatest experience of engaging in pro social roles and adhering to social norms (see section 6.3.3). These experiences seemed to be vital in allowing them to recognise and adhere to wider social norms, supporting their positive trajectories.

7.3.2: ‘Young and Excluded’

The two ‘young and excluded’ participants experienced environmental factors that were representative of other participants but were also distinct. For example, the essential role of romantic relationships around periods of relapse and the dominant role of financial issues were both specific to this ‘type’.

Housing

One of the ‘young and excluded’ participants was housed in an area of high-density social housing, and another in an area relatively close to the main cluster of homeless services in the city. However, within these broad areas each were housed considerable distances away from homeless services and the highest density social housing (high rise blocks) respectively. In turn, the likelihood of encounter homeless

associates and the negative consequences this generally brought was lessened relative to other participants, as explained in subsequent sections.

Gary was initially offered a flat in a particularly infamous street but after speaking to his prospective neighbours he abandoned this tenancy after only two weeks. After a short period of 'sofa surfing' Gary was rehoused by the service. Although he was forced to live in a homeless situation in between his two properties, Gary was clearly afforded some degree of choice over his housing location and type.

Similarly to the 'middle aged desisters' both developed strong relationships with immediate neighbours. However, rather than these relationships being based on 'neighbourly' values of practical support and congeniality, they became social relationships. Over time, these social relationships caused small tensions, disagreements, which contributed to brief periods of relapse in the trajectories of Gary and Linda respectively. For Gary, his relationship with his landlord and his case manager was affected after he attempted to advocate for his upstairs neighbour over an issue with repairs. However, this led to a relapse in Gary's anger management and control issues⁴⁷, manifesting in aggressive outbursts to both his case manager and landlord⁴⁸. As highlighted in reference to the 'young and excluded' in section 6.3.2, these anger management issues had led to sanction in the past for Gary and Linda. These consistent experiences of negative emotions can limit self-control, increasing the likelihood of engaging deviant behaviours (Gallupe & Baron, 2010). These experiences highlight important considerations for the orientation of social networks in HF clients' destination communities. Neighbours can act as positive influences on recovery and desistance, but can also cause emotional stress.

⁴⁷ See section 6.3.2 for a more detailed discussion of Gary's anger management and control issues

⁴⁸ See section 3.5.2 for discussion of how negative emotions compromise individual's capacity to engage in a deliberative choice process and for self-control.

Local Social Networks

Both 'young and excluded' participants had ongoing but tense relationships with parents due to issues in adolescent years (see section 6.3.2). As a result, support was regularly offered by parents, but not accepted, limiting the resources available to each (EnglandKennedy & Horton, 2011).

Romantic relationships played an important role for both Gary and Linda. These romantic relationships varied in the support they offered. Linda's romantic relationship had been developed in hostels and had acted as a catalyst for wanting an independent property and for reducing alcohol intake. Gary's relationship was less supportive and was generally described by Gary as being volatile.

In turn, issues in Gary's relationship resulted in considerable emotional stress, leading to altercations. A combination of this emotional stress and Gary's needs around anger management led to a number of altercations, with criminal charges resulting for Gary. In turn, contributing to a negative 'turning point' (Clapham, 2003; Laub & Sampson, 1993) in Gary's trajectory, and a period of relapse in which he experienced increased substance use and mental health issues. Linda explained her period of relapse in relation to the monotony of a more settled life, of which her partner was a part. However, it was her partner who after posing an ultimatum, provided the motivation for Linda to desist from her substance use and re-engage with the relationship.

"She was buying green all the time when she was drinking, so we had about £150 left after we'd been paid. And then I decided that I just didn't want to live here anymore so she had to decide she was gonna stop drinking and sort the flat out or just carry on."

(Linda's partner)

"Interviewer: Ok so about 2 month you started to turn things back around?

Nar 3 month

Interviewer: And whys that?

Cos we got back together.”

(Linda. Fluctuating Trajectory)

These two examples demonstrate the paradoxical influence of romantic relationships in recovery and desistance processes (Topor et al., 2006) (see section 3.5.3). If HF clients are to utilise the choice and control provided by HF to pursue recovery and desistance, then service providers must account for romantic relationships. With its preference for client autonomy, the service cannot stop clients from engaging in relationships, but it may be important to be aware of potential triggers caused by relationship problems and aim to prevent these from leading to significant relapse.

Service Remit

Although neither possessed the same capabilities as ‘middle aged desisters’ they did have similarly low needs in comparison with the ‘ageing drinkers’ or ‘severely disadvantaged’ participants (see table 6.6 and section 6.3.2).

Subsequently, the service’s primary focus on tenancy sustainment was sufficient for this group. For example, each participant continued to use alcohol and marijuana but neither demonstrated active addictions. Further, once they had moved into their own tenancy each reported that they were satisfied with their substance use.

The key issue faced by both was accepting financial responsibility for their tenancy. This is perhaps unsurprising; as both had been evicted for rent arrears in the past (see section 6.3.2). Both had agreed to paying ‘top ups’ on their rent but neither had consistently maintained the motivation or memory to continue paying these top ups. In turn, both lied to their case managers. The experiences of Gary and Linda support the link between previous experience of tenancy sustainment and current capacity to engage with these tasks.

Nevertheless, when confronted by their landlords both had the capacity to set up payment plans or pay large amounts off their debts. Although, these issues did cause tensions in the relationships between each 'young and excluded' participant and their case manager. In Linda's case, it has led to a complete disengagement with the service:

"She says she's set up a direct debit to pay the top up. The landlord's sent me an email to say that £300 and something, I've challenged her, because they've blatantly lied to me. Because I've asked them, is your top up paid, I've been sent this email. Now they aren't very happy that I've got the email and challenged it, but it's only because I've caught them lying. Since then they've totally disengaged."

(Linda's Case Manager)

This situation demonstrates the difficult balance case managers must strike between adhering to the philosophy of client autonomy, choice, and control, and ensuring the client carries out the necessary tasks to maintain their tenancy. In this situation, Linda's case manager's actions have led to disengagement, but equally, inaction may have led to eviction.

Wider Service Stakeholders

Neither Gary nor Linda had any explicit conditions placed on their receipt of benefits. As such, they experienced limited impact from wider stakeholders on their material resources, or opportunities for action. Both did face minor issues with their flats, which they had considerable disagreement with their landlords over. In both cases, landlords did not carry out repairs, and in Gary's case he was threatened with illegal eviction because he failed to report a repair quick enough to his landlord prior to an inspection, as highlighted in my observation after an update from Gary's case manager:

"[Case Manager] was present and when he arrived asked Gary why he had a blanket on the floor. When the landlord arrived he asked the same

question and lifted the blanket up to find tab burns and stains. He also found a leaking boiler which has caused water damage to the cupboards. Gary has not reported the boiler so he is now liable to pay the charges out of his deposit (which was paid by the service). The landlord told Gary in no uncertain and 'authoritative' terms that if he did not keep the flat well and pay his top up that he would be evicted, even without a section 21. He would 'get a couple of lads to come round'"

It is clear in this example that the power relationship between Gary and his landlord is highly imbalanced (Clarke et al., 2008). Gary holds little power to retain his flat other than complying with his landlord. As housing is an essential foundation for wider social inclusion and the pursuit of other outcomes, Gary's earlier concerns are understandable (see section 7.2.1). This is particularly poignant when we consider Gary's deep set issues with authority which originate from his adolescence and the fact that he has twice before faced what he describes as an illegal eviction⁴⁹. Gary's capacity to achieve ontological security or to perceive his flat as having the stability required to pursue longer-term outcomes is therefore restricted (Clapham 2010; King 2003).

7.3.3: 'Ageing Drinkers'

Housing

Each of the 'ageing drinkers' ended up in different housing situations. As noted earlier, Jimmy was placed in social housing, but this was within a high rise block in the same broad area of high density social housing as Joseph. In line with Arnie's priority to be close to his 'homeless family' he was housed in close proximity to many of the city's homeless services and accommodation projects.

⁴⁹ See section 6.3.2 or Appendix B.2.2 for discussion of Gary's issues with authority

The common theme across these three participants was their close proximity to homeless or formerly homeless associates. The impact of these associates is described in reference 'ageing drinkers' local social networks. However, for Jimmy the issue was not only with formerly homeless associates. Jimmy's sense of isolation led him to go out into the area in front of his block. However, he faced persistent abuse from children in the local area:

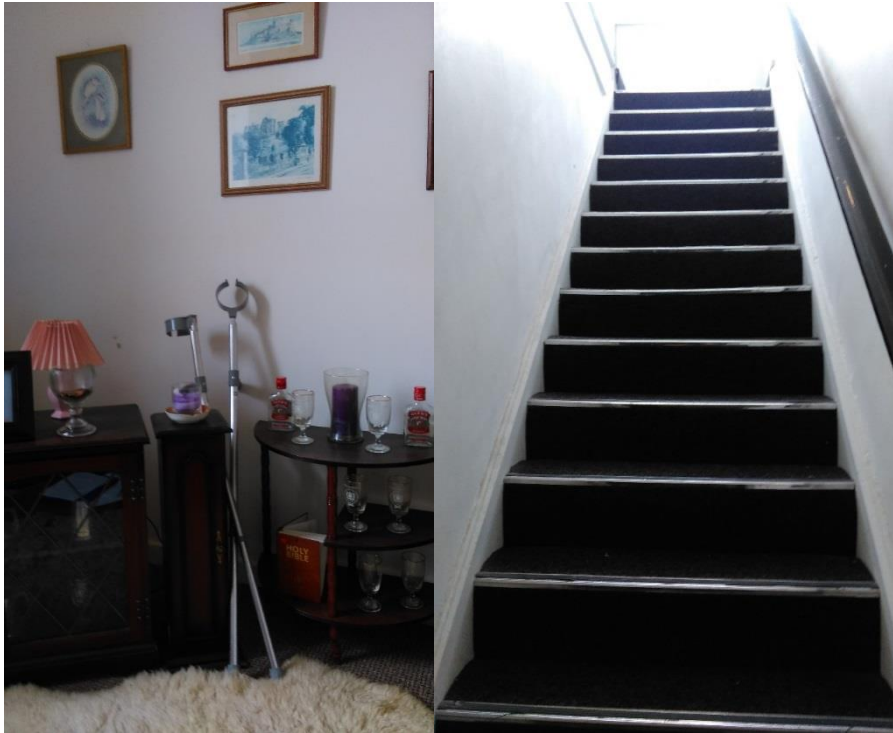
"The kids give me a bit of banter, 'here you drunk old b*****d! You know.' Throw stones at me sometimes, spit, but I got the police to get them all out of here, so they've backed off a bit, cos they know if I could run I would knock them out no problem."
(Jimmy. Static Trajectory)

Liam faced similar issues with isolation. He was one of the first clients housed by the service and had the option of moving outside of Newcastle. Liam was placed in an area on the outskirts of Gateshead. Consequently, Liam was largely isolated from any social contact other than from his case manager and his regular visits to hospital. Isolation was also a key challenge for participants in Johnsen's (2014) evaluation of the HF service in Glasgow. When considering the overwhelmingly negative orientation of participants' social networks it seems that many HF clients faced the choice of 'no company or bad company'. Evidence from this study supports findings from Nelson et al., (2015) which suggest that these issues are compounded further by longer immersion in 'street culture'.

The physical make-up of housing also played an important role in determining these participants capacity for choice and control over day to day life. 'Ageing drinkers' presented significant physical health issues which restricted their mobility. The two participants who faced the greatest mobility issues were Liam and Jimmy. These two participants were also those placed in housing that was least conducive to mobility issues. Jimmy was on the 12th floor of a high rise block and Liam was in an upstairs flat atop a steep flight of stairs. For each, the physical

structure of their accommodation constrained meaning and purpose, rather than providing the opportunity and resources to pursue other subjectively important outcomes (Clapham, 2011).

Figure 7.1: Liam's crutches and the stairs up to his flat



The service did aim to move each of these participants to more conducive housing (a bungalow for Jimmy and a ground floor flat for Liam). Liam had the option of moving to a ground floor flat in the same block but refused to move. Liam's refusal is seemingly irrational since he is largely housebound. However, after almost 15 years primarily spent rough sleeping, Liam seems to have grown attached to his flat. In turn, his ongoing health issues lowered his motivation to move.

Case Manager: Well let is finish, if you don't want to move and you're managing the stairs, cos you make is feel guilty when you say you're housebound right...

Well let me ask you, would you like to sleep in a coal bunker or have your own place?

Case Manager: it's a lovely one bedroom flat!

It's big for me and I don't want it.

(Liam. Static Trajectory)

Jimmy's did desire a move to a set of council bungalows near his flat. However, as highlighted in the below observational note, an incident of ASB excluded him from this:

"[Case Manager] had pushed for Jimmy to be on the list for a bungalow due to his mobility issues which make his 12th floor flat unsuitable. YHN were receptive and were looking to put him on the list. However, the housing office for the area is right outside of Jimmy's block where he also sits and drinks often. Jimmy saw two workers one morning and apparently while very drunk tried to go for one of them. Apparently this cost him the bungalow."

This example highlighted the limited remit of the HF service in determining whether clients are able to retain housing. Even in a HF service which positions housing as a human right, and does not impose specific behavioural conditions Jimmy has been excluded from a housing option in keeping with his own desires and needs. The unfortunate impact of this was a severe period of relapse in which he returned to early morning drinking and to spirits. Even more disappointing is that Jimmy had eluded to this relapse in previous waves:

"If I don't get the bungalow I'm just gonna go back on the piss again"
(Jimmy. Static Trajectory)

Ultimately in Jimmy's case, his transgressive preferences for action, encouraged by his long term alcohol use have continued to conflict with norms governing appropriate behaviour. In this case, this conflict related to fears that Jimmy would disrupt other elderly residents living in the bungalows. As a consequence, Jimmy continued to face exclusion from housing that is appropriate to his needs. In turn, limiting Jimmy's ability to utilise his housing as a foundation to pursue his own version of recovery is limited (Clapham, 2010; King, 2003)

Local Social Networks – Consequences of Loneliness

All but Arnie noted that associates they had developed in a homeless setting were overwhelming negative. For many their first priority was separating from these individuals (see section 5.2.1). However, the extent to which participants were able to do so varied. As noted in the previous section, Liam's housing location allowed him to separate from the influence of associates. However, Liam's alcohol use and issues with depression persisted due to the emotional impact of his isolation. Jimmy also faced consequences of feelings of depression and isolation related to mobility issues. Jimmy was a regular victim of stealing and financial exploitation by other residents in the block. As he put it:

"I get drunk, fall asleep and they take, take."

(Jimmy. Static Trajectory)

Joseph also faced financial exploitation from a few associates who he paid to spend time with him. Joseph's case is considered in more detail in section 7.3.3, as unlike the other participants, he experienced a positive trajectory.

Arnie's attachment to his 'homeless family' can be seen as a desire for social contact too. However, Arnie's explicit desire to be close to these individuals led to the greatest impact on his trajectory. Rather than a key resource, providing an opportunity to pursue recovery, Arnie's house essentially became a resource for his homeless associates as a place to socialise, engage in substance use and for those who were street homeless, a place to sleep. Arnie consistently expressed a desire to reduce his alcohol use but as highlighted by his case manager, there was little chance of pursuing this priority while retaining close links with his homeless associates.

"Just taking the alcohol out, but still having rough sleepers in your house, still spending your day's begging, still coming into [rough sleeper day centre], still doing all the same things. It's much more likely that they're going to negatively affect his sobriety."

(Arnie's Case Manager)

As outlined in section 6.3.3, the 'ageing drinkers' had, at best, very loose ties to family. Arnie and Joseph had not spoken to their family in decades, Jimmy and Liam were in contact with their family but these relationships could not be perceived as positive or supportive. Jimmy did make a trip to Glasgow to visit his sister but this visit ended in criminal charges for Jimmy.

These experiences highlight further the challenge of either facing social isolation or risk negative consequences in developing links with either associates or family members. The sharp contrast between these experiences and those of the 'middle aged desisters' highlight the importance of having positive, supportive social networks. The recovery and desistance literature outlined in Chapters 2 and 3 highlight the importance of separating from negatively orientated social networks and developing links with positively orientated ones (Bradshaw et al., 2007; Laudet et al., 2000; Laudet & White, 2008; Mezzina et al., 2006; Tew et al., 2011; Topor et al., 2006). However, none acknowledges the issues faced by participants who upon separating from negative networks cannot reasonably access positive ones. The result is a significant barrier to their ability to achieve greater community integration (Quilgars & Pleace, 2016).

Explaining Joseph's Positive Trajectory

At this point, it is useful to clarify the key factors which seemed to contribute to Joseph's positive trajectory. This contrasts from all other 'ageing drinkers', who experienced a static trajectory.

Joseph's life history does offer some explanation. A key difference between Joseph and other 'ageing drinkers' is that he did not experience profound trauma related to the death of a close loved one in the same way that other 'ageing drinkers' did. We may understand that Joseph's mental health and alcohol use were

less profound as they were not underpinned by such trauma (Maté, 2010; Fitzpatrick et al., 2012)⁵⁰.

However, the key factor in Joseph's more positive trajectory was environmental. Joseph was sanctioned for 12 months after failing to attend an appointment about his Employment Support Allowance. This sanction had a significantly negative impact on Joseph's income and in turn, his opportunities for choice. However, the sanction did also have a positive effect on Joseph's trajectory. Prior to this sanction, a high number of homeless associates were frequenting Joseph's flat. The reason behind this was his relatively high level of benefit allowance. In a similar manner to Jimmy, Joseph was regularly financially exploited by these individuals and faced repeated sanction for ASB related issues in and around his flat. Further, his alcohol use increased in the company of other heavy alcohol users.

When Joseph's money was stopped he experienced a positive 'turning point' in his trajectory, as these associates stopped frequenting his flat and his alcohol use, and ASB related issues reduced rapidly (Clapham, 2003; Holland & Thomson, 2009; Laub & Sampson, 1993). As a result, his mental health generally improved. Importantly, the service mitigated the impact of the material sanction he faced by supporting him financially, preventing eviction and providing essential items through food bank provision, while working on the appeal of his sanction.

"For, Joseph I think it's because he's had no money but he has cut down significantly on what he had been drinking on the streets. There's less charges against him, he's not getting arrested daily for drunk and disorderly and indecent exposure, disturbing the peace. He had 100 odd charges a year at one point, now he's down to 2 or 3. I'm not saying its ok what he did, but his offending is significantly reduced."

(Case manager)

⁵⁰ See section 3.5.2 for discussion of the relationship between trauma and substance use

It is important to note that being sanctioned did have a significantly negative effect on Joseph's mental health. Nevertheless, alleviating the negative impact of associates shifted his trajectory towards a positive one. However, during the final wave of the study, Joseph had received a large lump sum back payment from DWP, which jeopardised his ongoing positive trajectory.

Joseph's situation is an example of how HF services in different service delivery and policy contexts must contend with very particular challenges (Baker & Evans, 2016; Raitakari & Juhila, 2015). The ethnographic methods used in this study, combined with individual level analysis have allowed the nuanced nature of these challenges to become clear. In this case, the UK government's policy agenda of increased conditionality and sanction for those who do not adhere to this conditionality⁵¹ resulted in significant time and public money spent by the HF service trying to keep Joseph in his tenancy. There were positive consequences of the sanction, but these cannot be reasonably assumed as an intended outcome of sanctioning Joseph.

Service and Wider Service Stakeholders

In some ways the 'ageing drinkers' represented a relatively easy group to manage and maintain. Generally, they did not cause a great deal of damage to their properties and with significant support from the service, kept up with their financial responsibilities. Each of these participants retained their accommodation and were no longer facing the negative consequences of rough sleeping. However, all either faced social isolation, or upon seeking social contact were faced with considerable negative consequences. This highlights one issue with the dominance of housing

⁵¹ See section 2.8.1 for discussion of the welfare policy context in the UK

retention statistics as a measure of success in HF. Housing retention alone was not sufficient to enable positive change in their lives.

Unlike, most other participants, mental health and substance use services were not the key form of support which 'ageing drinkers' required. Most did wish to reduce their alcohol use but consistently lacked motivation to overcome their issues at such a subjectively late point in life. These findings support those of in the Canadian implementation, which highlighted hopelessness as a factor in determining negative trajectories in HF (Nelson et al., 2015; Patterson et al., 2013). They also offer some support for Sen's (1993) contention that deprivation can lead individuals to lower expectations. However, if Sen's contention was we would expect the same experiences across all participants, particularly those classified as 'severely disadvantaged'. In fact, the 'ageing drinkers' were amongst the participants with the most relevant capabilities (see section 6.3.3).

This was combined with the fact that they had been through treatment in the past and found it was unsuccessful. The key needs these individuals faced were social care needs. However, as each did also present with alcohol issues and when drunk, volatile behaviour the service struggled to access this form of support. Although, the particulars are different, the experiences of these 'ageing drinkers' once again highlighted the ongoing barriers MEH adults face in accessing essential services due to the conflict between their behaviours and wider social norms which preference civilised behaviour.

These experiences also highlight wider considerations for HF service's that promote 'open ended support' (Tsemberis, 2010, see section 2.7.3). Even within ACT models of support used in larger 'Pathways HF' implementations social care needs are not often considered (Aubry et al., 2015; Bond et al., 2001; Tsemberis, 2013). However, like Jimmy and Liam, many MEH adults are likely to experience complex physical health needs in later life that will require this form of support.

Without it, the 'choice and control' of these individuals, as well as their wider ability to pursue subjectively desirable outcomes is limited.

7.3.4: 'Severely Disadvantaged'

Housing and Interpersonal Networks

For the severely disadvantaged cohort, the key housing related factors were to do with the role of their local social networks, specifically the negative influence of associates. Once again emphasising the importance of these networks in influencing the choices of MEH adults away from recovery (Dingle et al., 2016; Laudet et al., 2008; Nelson et al., 2015). Before going into this area of discussion, it is worth noting the lack of familial support available to these participants.

All but Carl had cut all ties with family due to previous abuse or neglect, meaning they did not have the same emotional or material resources to draw upon as 'middle aged desisters' (EnglandKennedy & Horton, 2011). Carl did have extended family who offered considerable practical support, reminding him of bill payments for example.

Three of the 'severely disadvantaged' cluster were housed in an area close to the many of the city's homeless services and accommodation projects. An earlier quote by Lenny in section 5.4.7 demonstrates the negative influence of other people living in this area:

"It's right on top of is, constantly. I've got 3 drug dealers in my street, there's 2 drug dealers just across in the next street, then behind is there's another 2 drug dealers. It's just tempting all the time ... Banging on the door, middle of the night, twos and threes in the morning ... If you don't let them in they start kicking your doors and things like that."

(Lenny. Static trajectory)

Unlike some of the 'ageing drinkers' Lenny describes a situation in which he did not have the choice of 'no company or bad company'. Instead, he was housed in an area in which social norms continued to encourage substance use. As a result he was faced with consistent temptation and provocation from associates who sought to utilise his flat as a place to stay and drink (Wikström, 2014). Each of these motivators offered encouragement to Lenny to continue to engage in behavioural preferences that compounded his needs⁵². Further, the consequences of not allowing them in would have been damage to his flat. Overall, the action alternatives available to Lenny were limited by his local social networks.

Carl and James were offered properties in the areas in which they grew up after explicitly expressing desire to be away from homeless associates and the city centre. However, both encountered considerable set back because of associations developed before they entered homeless hostels. These individuals experienced many of the same needs as those in homeless hostels and so offered the same level of provocation and temptation.

"that's where I'm from, back with me pals and stuff like that. I'm safe in Gateshead, I've got nee problems, ya nar what I mean."

(James. Fluctuating Trajectory)

Despite his initial optimism, James' flat became the most obvious example of a property becoming a resource for homeless associates rather than a 'home' offering ontological security and a foundation from which to pursue other outcomes (Clapham, 2010, see section 2.7.1). After inviting a few associates round, more began to visit and his flat became a place. James' experience also presents an example of the duality of choice and responsibility in HF (Löfstrand & Juhila, 2012; see section 2.7.5). As outlined in figure 5.3 (section 5.3.1) James faced significant

⁵² See section 3.5.1 for further discussion of the role of motivators in a situational approach

consequences for engaging in the same behaviours as he did in a homelessness setting. Once his flat was overrun by associates, he had little control over his property, but he did still bear responsibility for what happened there, facing significant sanctions as a result (Elster, 2009). The behavioural autonomy offered by HF to clients is designed to remove paternalistic conditions and the 'multiple exclusion' which results (Padgett et al., 2006; Tsemberis et al., 2004). James' experience highlights a situation in which this autonomy, can lead to more prominent forms of exclusion, in this case imprisonment and eviction.

For Carl and Lyla, their neighbours were 'grow houses' for marijuana. Each faced significant consequences resulting from this. After an incident with her neighbours Lyla was forced to flee her property after threats were made on her life by the people who run the 'grow house'. Carl's best friend was killed in an incident related to Carl's associates and neighbours, the emotional stress from this event caused a significant relapse in mental health and substance use for Carl as he resorted to familiar preferences for affective relief brought by increased substance use (Buchanan, 2004; Dwyer et al., 2011; Maté, 2010). This significant trauma closely related to the death of his best friend when he was a teenager, to which Carl partially attributed his mental health and substance misuse issues (see section 6.3.4 and Appendix B.2.1). Findings from the Lisbon implementation of HF Europe identified that around a third of participants knew their neighbours, indicating positive community integration (Busch-Geertsema, 2013). These findings suggest that interaction with neighbours may not always be positive and can bring damaging consequences.

Ongoing engagement in 'street culture' activities amongst all of the 'severely disadvantaged' participants also contributed to the maintenance of these social networks. In this study, as in others (Volk et al., 2015), the extent of participants' immersion in street culture (largely influenced by the length of time they spent in a

homeless setting prior to HF) correlated to the extent to which they continued to engage in these behaviours⁵³.

Unlike other 'types', 'severely disadvantaged' participants engaged in expensive and illegal poly substance use. Earning additional income to pay for these substances and continuing to access dealers to buy these substances held these participants in social networks to a greater extent. As these participants possessed few other realistic capabilities or opportunities to make money, begging was the most feasible option (Petersen, 2009; Sen, 1993) (see 6.3.4). To engage in begging, participants then had to go to city centre locations where they encountered homeless associates. For all of these reasons, the situational capacity of these participants to separate from associates, substance use, and other associated issues was more limited than it was for other 'types'.

These findings offer some explanation of why those participants with the greatest needs have struggled in HF in the Canadian 'Chez Soi' implementation (Volk et al., 2015). They also help to explain the connection between greater connections to street based social networks and poorer outcomes in HF.

Service and Wider Service Stakeholders

An imbalance emerged between the high level of needs amongst severely disadvantaged participants and the housing focused support offered by the HF service. This limited the capacity of these participants to gain control over their needs and pursue capabilities associated to a positive and meaningful life

This 'type' had more 'multiple and complex' needs than any other in this study. Consequently, they required effective multi-disciplinary support across each domain of need more than any other 'type'. Therefore, the 'severely disadvantaged'

⁵³ See Appendix B.2.1 for explicit discussion of participants' immersion in 'street culture' activities

participants most clearly demonstrated the challenges faced by the service in 'signposting' to multi-disciplinary support.

Their issues were underpinned by traumatic experiences and compounded through lifetimes of social exclusion (see section 6.3.4). In particular, access to mental health support, and to a lesser extent substance misuse treatment was fraught with difficulty. These services commonly placed conditions of reduction or even cessation before offering treatment. In turn, the participant is 'responsibilised' for behaviour arguably symptomatic of their mental health issues (Whiteford, 2010):

"It's hard like you know, they diagnosed is, the EIP (early intervention psychosis) team diagnosed is with paranoia but then they say they're not willing to work with is until I reduce me drug and alcohol intake."

(Lyla. Fluctuating Trajectory)

Lyla's experience is a clear example of the barriers posed by 'dual diagnosis' (Cunningham et al., 1993; Laudet et al., 2000; Drake et al., 2004; Priester et al., 2016). A combination of conditionality and reduced capacity since 2010 are also likely to have contributed to participants' exclusion (Bradshaw et al., 2015; Etherington & Daguerre, 2015; Kings Fund, 2015; Peck, 2012)⁵⁴. A number of support workers highlighted the impact of these funding changes:

"I mean her CPN, who's stowed off, I mean that guy's got too many clients, and they're all really chaotic... he just spends hour after hour after hour in meetings talking about clients... So his face to face time with clients is very limited"

(Case Manager)

⁵⁴ See sections 2.8.2 for discussion of the barriers posed in accessing multi-disciplinary support and 2.8.1 for a discussion of the wider policy context and influence of austerity measures. See section 3.5.3 where these barriers are situated in the wider concept of 'opportunities'

Without appropriate mental health treatment, it is likely that the capacity of these individuals to deal with their mental health issues is diminished. As sections 3.5.2 and 6.3.4 highlight, mental health issues related to traumatic experiences often underpin other needs of MEH individuals, which have been developed as behavioural preferences to deal with the emotional stress of these experiences. Therefore, without sufficient support and treatment, the capacity of participants to gain control over these needs and pursue capabilities associated with a meaningful and positive life is also diminished.

7.4: Conclusion

This chapter has primarily focused on the factors within participants' settings (environmental factors) which have converged to either enable or hinder their capacity for choice and control over their trajectory. Section 7.2 introduced factors related to domains of housing, support, and social networks, which affected all participants. Macro level, structural factors related to UK welfare policy and housing rental market affordability both set broad limitations on participants' capacity for choice over their housing. In particular, the intersection of participants' housing histories, level of income, and market based PRS accommodation meant that only a relatively small amount of properties were available. Findings presented in section 7.2.1 highlight the clear power imbalance between landlord and tenant, in favour of the landlord, which restricted many participants' sense of ontological security and control over their property.

A more balanced relationship existed between participants and case managers. This is a key outcome associated to a HF philosophy and of 'choice' mechanisms more broadly. However, in this study, it led to frustration amongst case managers and subsequent desire for conditions around 'readiness' and 'end points'. Service managers were essential in challenging these frustrations and reminding staff of the strength of a client led approach.

Section 7.2.3 outlined the important role of local social networks in influencing participants' capacity to pursue recovery and desistance orientated outcomes. In line with other HF studies, formerly homeless associates were identified as having a universally negative impact on participants' trajectories, encouraging behavioural preferences that compounded participants' needs.

Section 7.3 was structured according to the environmental factors which consistently affected each 'type'. In doing so, this section brought together factors relating to 'person' and 'setting'. As outlined in section 7.3.1, 'Middle aged desisters' tended to face the least factors which hindered their capacity for choice and control. In turn, they benefited from the most facilitative factors, particularly around the supportive and positive orientation of their local social networks. In turn, the service's remit fitted well with the needs and capabilities of these clients, each of whom were able to access the support they required to pursue a positive trajectory.

The trajectories of the 'young and excluded' participants were most affected by romantic relationships and financial problems. Romantic relationships had variable impacts, for one participant they brought relapse and criminal charges; for another they encouraged a decision to halt a period of relapse. Each 'young and excluded' participant had problems in maintaining their rent payments. This was consistent with their previous experience of independent tenancies (see section 6.3.2).

For some 'Ageing Drinkers', their control over their day to day life was restricted by mobility issues, which limited their capability to carry out essential tasks. Living in upper level flats restricted the mobility of these participants further. In turn, each of the 'ageing drinkers' faced the dilemma of 'bad company or no company'. For each associates had a negative impact on their trajectories, but the alternative was social isolation. In either scenario, participants' alcohol use

continued. Joseph did manage to gain greater control over his alcohol use, amidst a positive trajectory. Joseph's case is discussed separately in section 7.3.3.

Lastly, the 'severely disadvantaged' cohort faced the greatest range of barriers to choice and control over their trajectories. In turn, they had very few facilitative factors on which to draw other than their case managers. Particularly significant among this group was their ongoing exclusion from mental health services essential to enabling more positive trajectories.

The final chapter of this thesis considers the differences between each of these cohorts further along with what this means for HF, both in Newcastle and England. These considerations are set within a concluding discussion of the key objectives, approaches, limitations, findings, and propositions of the study.

8: Concluding Discussion

Giving clients 'choice and control' has been promoted as key principle of the HF model and a key mechanism of 'recovery orientated' approaches more generally. 'Choice and control' is deemed to be both humane and effective, enabling clients to achieve outcomes associated with a more positive and meaningful life (Padgett et al., 2006; Tsemberis et al., 2004). This thesis sought to examine the role of 'choice and control' in the achievement of 'successful' outcomes in HF, within the social, political, and economic context of a single implementation.

Three primary research objectives were identified in order to aid exploration of this aim:

- To establish the desired outcomes of Housing First for clients, and how these fit with wider definitions of 'success' for 'Multiply Excluded Homeless' adults.
- To explore the extent to which 'choice and control' was available to clients
- To explore which environmental and biographical factors affect clients' ability to utilise 'choice and control' to achieve outcomes.

The thesis began by offering a contextual introduction to the origins, philosophy, proliferation, and evidence base of the HF model. This chapter identified that most HF studies define success in terms of the housing retention and service satisfaction. Longer-term 'recovery orientated' outcomes are less forthcoming, and only limited enquiry has been undertaken into the factors which promote, or impede recovery.

Chapter 3 outlined the theoretical framework for the study. A situational approach was identified as a particularly useful framework for identifying the biographical and environmental factors that influence participants' ability to make 'recovery orientated' choices. This framework was translated into a methodological

approach in Chapter 4. A qualitative longitudinal approach was used as the basis of the methodology, although some ethnographic and quantitative elements were also incorporated. Finally, the three findings chapters explored the primary research objectives. Chapter 5 established the desired outcomes of HF for participants, placing these wider definitions of 'success' for MEH adults into context. Chapters 6 and 7 highlighted the contextual and biographical factors that affect participants' ability to utilise choice to achieve outcomes, with reference to situational categories of 'person' and 'environment'. In doing so, they examined the role of 'choice and control' in the achievement of 'successful outcomes'.

This chapter aims to conclude the thesis by summarising and discussing the key findings and propositions of the study.

Section 8.2 covers the context of this study. Discussion focused on the particularities of delivering HF in England, where the model is still new.

Section 8.3 consolidates findings on 'success in HF'. In doing so, the section draws together findings relating to *the desired outcomes of Housing First for clients, and how these fit with wider definitions of 'success' for 'Multiply Excluded Homeless' adults.*

Section 8.4 draws together the key findings which explain variability in participants' ability to utilise 'choice and control' to pursue trajectories towards recovery. In doing so, this section offers conclusions on *the extent to which 'choice and control' was available to clients* and consolidates *the environmental and biographical factors affected clients' ability to utilise 'choice and control' to achieve outcomes.*

Section 8.5 offers a final conclusion on whether 'choice and control is both humane and effective, as well as some key recommendations which have emerged from the study.

Before this concluding discussion, section 8.1 consolidates the key limitations of this study, each of which are highlighted in more detail throughout the thesis.

8.1: Limitations of the Study

The first and perhaps most substantial limitation of this study is that the evidence from which conclusions are drawn come from a single implementation of HF, within a particular context of service delivery. In turn, participants' recovery processes took place in the specific social and economic context of Newcastle-upon-Tyne. However, as highlighted throughout Chapters 5 to 7, many of this study's findings are representative of implementations in other contexts. In turn, findings related to the impact of housing market pressures on participants in this study can indicate challenges for other HF implementations in the UK. If housing market stresses affect participants capacity for choice, control and success in Newcastle, where there is much less pressure than other areas of the UK (ONS, 2016a), there are serious questions to be asked about the viability of a HF model using PRS accommodation elsewhere in the UK, for example London.

Second, this study did not directly compare HF to 'treatment as usual' (TAU) in Newcastle. Although this may have been useful, it was not this study's primary concern. A number of other, large-scale quantitatively orientated studies have already demonstrated better outcomes for HF than TAU by comparing the two groups using the same measures. The focus of this qualitative, longitudinal study was to gather rich, detailed data on individual participants' recovery trajectories, and the factors that facilitate or impede their capacity to utilise 'choice and control'. The study did collect their retrospective accounts of TAU as a point of comparison and as part of their 'starting point' in HF. For these reasons, this study makes a unique contribution to the HF literature.

The third limitation of this study is the risk of performative responses from participants, both on their outcome priorities and more broadly. However, a range of methods were used to mitigate this impact (see section 4.1.5). Most importantly, the flexibility and triangulation offered by the qualitative, longitudinal design of the study.

Fourth, the period of data collection was not long enough to measure sustainable change in participants' lives. Anecdotal evidence has already suggested some change in participants trajectories since data collection concluded.

Unfortunately, this study was limited by the time constraints of PhD research. It was for this reason, that trajectories were used as indicative measures of change.

Ideally, additional funding will be sought to follow up on participants' progress over longer periods.

8.2: Delivering Housing First in England: Negotiating a Culture Change and going beyond Housing Retention

A number of academics have argued for further research into how HF is implemented in different local contexts (Kertesz et al., 2009; McNaughton Nicholls & Atherton, 2011; Raitakari & Juhila, 2015)(see section 2.6.2). This study responded to this call, exploring how the model, and the principle of 'choice and control' more specifically, manifest in Newcastle.

HF emerged as a response to models of accommodation and support in homeless provision, which were widely criticised for being inhumane. These models were broadly informed by a 'treatment first' philosophy and linear design, requiring clients to adhere to certain standards of behaviour in order to progress to more independent forms of housing, with greater degrees of control.

These critiques have also emphasised how a 'treatment first' philosophy leads to exclusion of individuals with 'multiple and complex' needs, leading them to become 'trapped' in affective cycles in which needs are compounded. These critiques were borne out in the experiences of participants in this study, as they

described their time being accommodated in congregate homeless provision, largely guided by a 'treatment first' philosophy. Participants consistently described affective cycles in which substance use and violence, as well as exploitative and 'shallow' social relationships characterised their day-to-day life (see section 6.2). These affective cycles both conflicted with, and resulted from conditions designed to encourage desistance from these behaviours. Unable to desist, participants were excluded from congregate accommodation, or were unable to progress to more independent forms of accommodation. These findings challenge the perspectives of providers and policy makers in Johnsen and Teixeira's (2012) study, which suggested that HF was a less radical idea in the UK, with many reporting that they were 'doing it already' (see section 2.8). Linear models are still prominent in the UK, as are notions of 'housing readiness', which have parallels with a 'treatment first' philosophy. Participants consistently reported that HF gave them a chance to separate from this cycle (see section 5.2.2).

When asked about their philosophy of support, case managers in this study overwhelmingly responded by noting the importance of a client led approach (see section 6.2.3). However, a number of case managers also expressed a desire for greater conditions within the HF service (as discussed in section 7.2.2). This desire was understandable given their desire to encourage progression and the frustrating lack of progress many case managers were observing. In addition, many years spent working in congregate housing situations meant they were more accustomed to these methods of persuasion. Overall, these findings suggest that in Newcastle, staff attitudes can represent challenges to implementing the principles of HF, particularly around a client led approach, informed by client choice.

Immediate, independent housing is a key and radical principle of the HF model. This aspect of model has rightly taken a central role in the HF literature, and within the wider promotion of the model. In the UK, offering housing with floating

support informed by broad notions of 'client choice and control' is not new or radical (see section 2.8). However, this thesis has shown that HF is about going beyond abstract notions of choice and control, and instead delivering them alongside a 'package' of other complementary principles and support. These principles are informed by evidenced based approaches in substance misuse and mental health, and are fundamentally concerned with actively enabling long-term change in participants' lives. Most evaluations of HF have not been able to demonstrate significant change in these areas, but this is more likely to be the result of temporal limitations on study designs rather than any inherent failure of the model itself.

Very positive rates of housing retention have been at the centre of the model's proliferation across North America and Europe, alongside other positive outcomes promoting service satisfaction and improved subjective wellbeing (see Woodhall-Melnik & Dunn, 2015). Findings from this study re-affirm these positive results, but also pose questions about the extent to which housing acts a foundation without appropriate support, opportunities, and resources. Housing is a human right, but also the foundation for the pursuit of broader, more long lasting outcomes associated to a sustainable process of change. Findings in this study demonstrate the inherent risk that by delivering a HF service in a wider context of 'treatment first' philosophy, in which professionals believe they are already delivering HF, we lose sight of what HF is actually supposed to be. Not simply a means of housing MEH adults or a panacea for all their problems, but a means of providing appropriate support to them so they can pursue their own idea of a meaningful and positive life.

The other principles of HF, beyond 'immediate, independent housing' are focused on achieving this latter, more ambitious aim, and each has received relatively little attention in the literature (Raitakari & Juhila, 2015). As outlined in section 2.7, each of these principles are underpinned by a client led approach, enabled through the mechanism of offering choice to clients. Choice is also the

means by which clients are expected to guide decisions about their housing, support, and behaviour towards what they see as a subjectively positive and meaningful life. Without appropriate interrogation of 'what choice and control' actually means, they risk becoming empty platitudes.

Such interrogation must take account of the wider context in which the principles and mechanisms of HF are delivered. As highlighted in earlier paragraphs, this includes the service delivery context. However, the broader social, political, and economic context is also an essential point of enquiry. In reference to the mechanism of choice, this is particularly relevant in a UK context. It is from a UK context that the majority of critiques around choice agendas in public services emerged through the 1990's and 2000's (Holland & Thomson, 2009). Evidence presented in section 2.8.1 suggests that the context of service provision, affected by austerity and conditionality arguably exacerbates those critiques, placing greater responsibility on clients to pursue outcomes such as employment, in order to achieve wider social and economic inclusion. Paradoxically, austerity and welfare reform measures have limited the material resources and opportunities that an actor can draw upon to pursue this 'project of self' (see sections 2.8.1 and 3.5.3).

As a result, fundamental questions remain about whether choice is an effective mechanism for enabling clients to pursue a positive and meaningful life. Later chapters of this thesis began to answer these questions, the key findings from which are summarised in section 8.4.

8.3: Success: Housing First, What After?

There is a risk that alongside the proliferation of HF, a narrow definition of 'success', focused on housing outcomes, may prevail (McNaughton Nicholls & Atherton, 2008). To counteract this risk, this study sought to clarify the broader outcomes that HF clients may pursue. Given participants' experience of 'multiple and complex' needs, it was important to measure a broad range of possible

outcomes. Additionally, the recovery-orientated nature of HF, and this study's focus on 'client choice and control', underscored the need for personalisation in outcome measurement. Consequently, participants' personal priority outcomes were given additional weighting when determining trajectories. This incorporated some degree of personalisation in outcome measurement and *established the desired outcomes of Housing First for clients*. By measuring a broad spectrum of outcomes, it was also possible to establish whether 'what clients wanted' was in line with what the service wanted for them and whether participants' priorities represented a desire for recovery and desistance. In turn, this demonstrated how participants desired outcomes *fit with wider definitions of 'success' for 'Multiply Excluded Homeless' adults*.

8.2.1: What did clients want?

When personalising outcome measurement, Sen's (1993) capabilities approach was found to be a particularly useful perspective. However, not all of Sen's propositions were borne out in this study. For instance, Sen's contention that those who have faced deprivation are likely to have lower expectations was not wholly representative of participants' priorities. There was some support for Sen's contention, particularly among those participants categorised as 'ageing drinkers' who often expressed little hope that positive change was possible. However, many wanted to become employed, a goal which may be 'out of reach' for individuals with such complex needs. There is the possibility that participants' outcomes were ambitious because they were simply responding in a performative manner. In other words, they were outlining priorities that they thought I, and their case manager wanted to hear. However, the qualitative longitudinal approach taken in the study allowed mitigating strategies to be put in place, limiting this risk. Participants' priorities changed very little through the course of the study. This is not to say all participants consistently pursued their priorities. However, participants' ability to do

so was not simply a question of whether they desired these outcomes or not, it was instead a consequence of their situational capacity to utilise the choice and control offered to them, as explored in Chapters 6 and 7, and summarised in section 8.4 respectively.

Participants' priorities demonstrated close resemblance to those promoted by the service, and were broadly representative of a desire for recovery and desistance. These findings challenge the idea that participants have wilfully separated themselves from society, forming subcultures (Ravenhill, 2012). Instead, they point towards a clear desire to engage in behaviours and roles, which are representative of 'recovery' and wider social and economic inclusion. These desires were relatively uniform across participants, albeit with varying levels of deliberation over how they were going to reach these priorities.

When compared to retrospective accounts of time spent in congregate homeless accommodation, these priorities take on even greater relevance. In line with other studies exploring the priorities of homeless individuals, participants prioritised short-term relief in congregate homeless accommodation, with little consideration of longer-term outcomes (Bowpitt et al., 2011, Helfrich & Chan, 2013). In contrast, after entering the HF service, these participants expressed deliberative, long-term goals. These findings support the idea that the independent housing offered by HF gives individuals what they see as a realistic opportunity for positive change in their lives.

In summary, participants generally wanted positive change in line with service outcomes, broader definitions of success in recovery and desistance literature, and wider social norms. However, participants' ability to pursue these outcomes varied.

8.2.2: Trajectories of Change

As discussed in Chapter 5, the priority outcomes reported by participants did not always take account of other outcomes, which were likely to facilitate the pursuit of their priorities. Measuring progression towards ‘success’ therefore relied upon a broader range of outcomes. Consistent with the dual nature of recovery, outcome measurement focused both on overcoming ‘needs’ and developing relevant ‘capabilities’ for the pursuit of a positive and meaningful life (Bonney & Stickley, 2008; Groshkova & Best, 2011; Kazemian, 2007; White, 2007).

These ‘needs’ and ‘capabilities’ were drawn categorised into domains and sub-domains (see table 4.1 in section 4.1.5 for a full list of these). Across these domains, outcome achievement followed a similar trend to other evaluations of HF⁵⁵. Housing retention rates were generally favourable, as was service satisfaction and perceived sense of choice⁵⁶. However, as discussed in section 5.4.1 there were some important considerations around how housing retention was measured, which brought into question how positive housing retention rates were.

Outcomes relating to improvements in mental health, substance misuse, offending, and meaningful activities were less positive, and much more nuanced. However, by focusing analytical attention on individual cases it was possible to see consistent differences in each participants’ ability to achieve broader outcomes. Essentially, some participants were consistently achieving more positive outcomes than others were.

Exploring the overall outcome trajectories of individual participants is less common in evaluations of HF. Most studies are quantitatively orientated and report in terms of particular outcomes. However, some studies have used the concept of trajectories as a means of establishing pathways towards longer-term change

⁵⁵ See section 5.4 for outcomes in each domain, as measured in this study, and section 2.6 for outcomes in HF more generally.

⁵⁶ See section 6.2 for outcomes relating to perceived choice.

(Johnsen, 2014; Padgett et al., 2016; Patterson et al., 2013) (see section 2.6.3).

They did so amidst a recognition that overcoming needs and building a positive and meaningful life are likely to be long processes. Consequently, establishing concrete evidence of such change is likely to be outside of the remit of a study lasting only a few years. In each of these studies, trajectories have been varied. However, the majority of studies did demonstrate that most participants experienced positive trajectories.

As outlined at the end of Chapter 5, participants' outcome trajectories varied in this study. Four experienced positive trajectories towards recovery and desistance orientated outcomes, four experienced 'static' trajectories, with very little progression observed, and six experienced 'fluctuating trajectories' with periods of progression interrupted by relapse and set back. The distribution of trajectories in this study was more in keeping with the trajectories in Padgett et al. (2016), with the majority experiencing trajectories that could not be classified as positive or negative.

In contrast to Padgett et al. (2016) and others, no participants were categorised as experiencing a 'negative' life course in this study. Instead, a 'static' trajectory was conceived, which referred to those participants who had not made observable progress towards any outcomes. These participants' life histories revealed experiences of disadvantage, trauma, addiction, and exclusion. Categorising their time in HF as negative implies a worsening of their situation beyond these already negative experiences. Therefore, It was determined that the point at which a participants outcome would be deemed negative, was if it became worse than their time in a homeless situation. This decision represented the influences of the 'pathways', 'capabilities', and 'situational' approaches which inform this study. Each of which require the researcher to consider the person's past when measuring their present and future progress.

In both HF Glasgow and HF Canada, fluctuating trajectories were common, as they were in this study. These fluctuations are common amongst recovery and desistance literature, which highlight that set back and relapse are common, the causes of which can be personal or environmental in nature, or more commonly a combination of the two (Laudet & White, 2010; Terry & Cardwell, 2015). The rich data gathered by this study illuminated the particular ways in which these fluctuations can manifest (see section 5.3.1). Another key strength of this study is that through a situational approach, which incorporated participants' biographies, it was possible to identify those participants' at greatest risk of set back and relapse.

The situational approach directs the researcher's attention to both the participants' biography, and their setting at the time of choosing⁵⁷. In line with an analytical realist perspective, each of the factors that constitute these broad categories are explored through time and from the perspective of individual participants. This is because interpreting participants' perception is essential to understanding why they acted in the way that they did.

Of particular importance in participants' biographies are their needs and capabilities. A focus on both needs and capabilities highlighted participants 'starting point' when pursuing outcomes. The variations in participants' trajectories indicated that inequalities were present in their ability to direct choices about housing, support, behaviour towards desirable outcomes. A capabilities approach and a situational approach allowed for detailed interrogation into each participants' ability to pursue their own idea of a subjectively positive and meaningful life. The needs and capabilities of some participants aligned less well with the outcomes they sought to pursue. In turn, the resources and opportunities available in their immediate environment were not always sufficient to overcome the deficits in their capabilities.

⁵⁷ See section 3.5 for a detailed outline of the situational approach employed in this study.

8.4: Situational Inequalities in using ‘Choice and Control’ to achieve ‘Success’

Having highlighted inequities in participants’ outcome trajectories. This section primarily focuses on addressing the third research objective, exploring the key *environmental and biographical factors which affected clients’ ability to utilise ‘choice and control’ to achieve outcomes.*

First, it is important to discuss findings relating to the second research objective, *whether ‘choice’ was available to clients.* Evidence from other studies on ‘choice’ in HF suggested that this brings positive outcomes (see section 2.7.5). These studies primarily rely on participants’ perceived sense of choice, gathered through psychometric measures. Participants in this study did perceive themselves to have a high level of choice over housing, support, and behaviour in HF (see section 6.2). However, the more detailed qualitative evidence gathered in this study highlighted two important considerations, which pose questions for the validity of these responses. Firstly, evidence outlined in section 4.1.5 suggested that a number of participants responded performatively to Pearlin and Schooler’s ‘mastery’ scale. Greenwood et al. (2005) used this scale to demonstrate the link between choice and psychiatric outcomes. However, in this study, participants’ responses suggested very high levels of mastery, which conflicted with their overall accounts of their lives.

Second, when asked about perceived choice in HF, participants consistently compared to their time spent in homeless accommodation. Their accounts of congregate homeless accommodation were overwhelmingly negative, and focused heavily on how paternalistic this form of accommodation was. Therefore, that they perceived more choice in HF was not particularly surprising.

A more encompassing and ‘realistic’ interrogation of participants lived experiences of using choice was required. Chapter 3 explored theoretical perspectives on individual rationality and decision-making and highlighted a

situational approach that takes account of the complex interaction between person, environment, and time in determining individuals' choices and resulting actions. This approach was used to interrogate participants' 'situational' capacity to utilise choices in HF to move towards subjectively positive and meaningful lives.

A situational approach is rare in homelessness literature, but is complementary to contextual approaches to exploring rationality and action amongst homeless individuals (see section 3.4). On a broader level, a situational approach also compliments the 'new orthodoxy' in homelessness research, which directs attention to the complex interaction of personal, institutional, and structural factors, rather than focusing solely on one set of factors (Fitzpatrick, 2005).

Moreover, the analytical perspective, from which a situational approach emerges, compliments a pathways approach by focusing analysis first on the individual, before exploring commonalities across cases (see section 3.6). Processes of recovery and desistance are inherently personal pursuits. Exploring these pursuits from the perspective of the client allows a clearer picture of the factors influencing them. In a situational approach, those influences are categorised in terms of biographical and environmental data.

8.4.1: The Importance of Biographical Context

The vast majority of HF studies consider context in relation to the individual's environment, but neglect the importance of biographical context (see section 2.6). As a result, they gain only a partial picture of the factors that impede or facilitate positive change. Therefore, this study contributed to a key gap in the HF literature.

In this study, the nature of personal and environmental factors differed across participants. The combination of these factors meant that certain individuals were disadvantaged in their ability to pursue desirable outcomes. However, personal factors were dominant, predicting the nature and influence of environmental factors. The key reason for this was that participants' needs,

capabilities, and associated behavioural preferences married to varying extents with the HF model in Newcastle, and the wider opportunities for social and economic inclusion.

Chapter 6 was primarily concerned with these personal factors. MEH adults are commonly categorised as a particular subset of the population of the homeless population, differentiated by their 'multiple and complex' needs (Cornes et al., 2011). Through complex enquiry into not only participants' needs, but also their capabilities this study was able to highlight considerable variations in participants' life histories. These variations affected participants' ability to pursue the recovery and desistance orientated outcomes they desired. 'Mapping' participants' needs and capabilities alongside each other was a particularly useful means of identifying difference between them, as displayed in figures 6.1, 6.3, 6.5, and 6.7 respectively. Temporal mapping is promoted in qualitative longitudinal and pathways approaches, but also sets within the focus on 'time' with a situational approach.

All participants' life histories contained experiences of substance misuse and mental health issues, as well as traumatic experiences. However, detailed qualitative enquiry illuminated significant differences in the severity of these experiences. Immersion in 'street culture' activities and offending behaviours were present in the experiences of most, but not all participants. The severity and type of substance misuse issues, as well as the extent to which these were underpinned by traumatic experiences were key factors that affected participants' ability to make choices towards recovery and desistance. In turn, those participants who were more immersed in homeless situations and 'street culture' found it most difficult to amend their choices towards societal conceptualisations of a positive and meaningful life.

Participants' experiences of capabilities, relevant to pursuing desirable outcomes were also variable. No participants engaged well with education. Experiences of employment, substance misuse abstinence, tenancy sustainment,

and subjectively positive and supportive relationships all varied considerably amongst participants.

The ability to retain positive and supportive relationships, developed over an individual's life and present as they entered HF, was a key capability that encouraged recovery orientated choices. In turn, those with most experience of the tasks associated to tenancy sustainment were best able to utilise their HF tenancy as a foundation for the pursuit of other outcomes.

Chapter 6 concluded by highlighting four distinct types of participants, which have emerged as a product of their life histories: 'middle aged desisters', 'young and excluded', 'ageing drinkers', and 'severely disadvantaged' (see section 6.3.1). Each 'type' referred to a cluster of individuals who shared similar needs and capabilities, and behavioural preferences. The needs, capabilities, and preferences associated to each 'type' translated into particular challenges and advantages in HF.

This typology was specific to participants in this study. However, it was also representative of larger studies exploring MEH, and the closely associated issue of Severe and Multiple Disadvantage (SMD). In particular, the 'ageing drinkers' cluster bore close resemblance to Fitzpatrick et al's (2012) 'homelessness and street drinking' cluster both in terms of their primary substance use issue and age. Furthermore, the 'severely disadvantaged' cluster closely resembled Fitzpatrick and Bramley's (2015) 'SMD3' cluster and Fitzpatrick et al.'s (2012) 'homelessness, hard drugs and high complexity' cluster. Each represented those with the most adverse life histories, most complex needs and least developed capabilities. These resemblances demonstrate some external validity and generalisability of these findings. Further, the widespread similarities identified amongst homeless adults with 'multiple and complex needs' across North American and European countries suggests similar groups may be present in other populations (Toro, 2007) (see section 2.3).

The typology of participants' life histories was predictive of outcome trajectories in the study. Simply put, those with lowest needs and greatest range of capabilities were best able to progress towards desirable outcomes. 'Middle aged desisters' all experienced positive trajectories, and had the least severe needs and most developed capabilities. 'Ageing Drinkers' were most likely to experience static trajectories, largely due to limited motivation affected by ongoing physical health issues related to chronic alcohol use. Similarly, a sense of hopelessness was found as a key barrier to positive change in the Canadian 'Chez Soi' implementation (Nelson et al., 2015). 'Young and Excluded' participants each experienced fluctuating trajectories due to issues with 'binge' substance misuse and emotional management during times of stress. 'Severely Disadvantaged' participants were also most likely to experience fluctuating trajectories, and were most likely to experience eviction. These participants faced the greatest level of needs, with particularly severe mental health and poly substance use issues, underpinned by trauma. As a result, they had little opportunity in their lives to develop capabilities useful in pursuing desirable outcomes⁵⁸. These findings support those of Volk et al. (2015), who found that those with the most complex life histories were least likely to remain stably housed (see section 2.6.2).

The findings of this study highlight the importance of participants' pasts in influencing their ability to exert choice and control over their present and future. Section 3.5.2 demonstrates how the most complex forms of substance misuse and mental health issues are related to adverse childhood conditions. The findings of this study demonstrate how these early life experiences can disadvantage participants' decades later, even in comparison those who have experienced trauma, substance misuse, offending, and mental health issues later in life.

⁵⁸ Section 6.4 explains the relationship between life history types and outcome trajectories in more detail.

However, personal factors alone do not tell the whole story of why some participants did better than others. Quantitative analysis by Volk et al. (2015) identified that many variables associated with complex life histories did not emerge as statistically significant predictors of housing stability. The qualitative approach taken in this study, which looked beyond housing stability, allowed the identification of important environmental factors which contributed to inequitable outcomes. Further, a situational approach, which both explored personal and environmental factors, demonstrated that environmental factors commonly mediated the impact of participants' life histories on their trajectories.

These environmental factors are discussed in more detail in Chapter 7. Early sections of Chapter 7 highlighted common factors which affected all participants' ability to exercise 'choice and control' over their housing. However, more nuanced, qualitative enquiry revealed that inequities in participants' needs, capabilities and preferences led to inequities in the impact of other environmental factors. The following sections concentrate on the key environmental factors, which mediated the impacted of participants' life histories.

8.4.2: Sourcing Housing from the PRS

As has been noted throughout this thesis, this study is primarily concerned with what comes after housing. However, housing is still an essential foundation for the pursuit of other outcomes. As such, the allocation of housing had significant consequences for participants' capacity for choice and control.

Although the service followed principles of 'choice and control', they found it particularly difficult to source an adequate range of housing from which to enable a realistic choice for clients. These issues demonstrate the challenges of trying to achieve 'independent, scattered site housing in the community'. By moving into the PRS, the service was confronted with landlords who were reluctant to rent to those with such complex life histories. These findings are consistent with the experiences

of housing benefit claimants more broadly (Spurr, 2017). Importantly, the service paid clients' deposits to enable access at all. However, a broader combination of factors including LHA rates⁵⁹, PRS market availability, and a cohort of 'undesirable' tenants meant that properties available were limited to those in less desirable areas. These issues affected all participants, limiting their choice and control over where they lived. However, those with more complex needs, and more transgressive behavioural preferences, ended up in locations that were less conducive to recovery.

Housing retention outcomes take prominence in HF literature, but there is very limited discussion of the challenges faced in sourcing housing⁶⁰. Housing was of a similar quality for all participants, although some 'ageing drinkers' did find themselves in housing unconducive to their mobility issues (see section 7.3.3). The location of housing arose as an important factor, determining participants' capacity for recovery and desistance orientated choices, primarily mediated through the local social networks in participants' destination communities.

8.4.3: The Orientation of Local Social Networks

The orientation of participants' local social networks played an important role in differentiating participants' situational capacity to make recovery and desistance orientated choices. These findings are consistent with those in other HF studies (Nelson et al., 2015; Padgett et al, 2016). The most prominent factor that affected all participants' trajectories were 'homeless associates', who had an overwhelmingly negative impact.

Volk et al. (2015) conceded that longer cumulative time spent homeless and greater connection to street based social networks warranted further investigation. The authors were particularly concerned about clients' ability to disengage from

⁵⁹ See section 2.8.1 for discussion on changes to LHA rates in recent years

⁶⁰ See Johnsen (2014) for one such example

these networks. In this study, the ability to disengage also emerged as a key difference between those participants' with positive trajectories, and those with fluctuating and negative trajectories. The qualitative orientation and 'small n' design of this study allowed for further investigation into the role of street based social networks.

'Middle aged desisters' were generally able to desist from the negative influence of homeless associates. However, they also faced the least difficulty in doing so. They had relatively little immersion in these networks, and had the significant alternative of positive and supportive family relationships to access. They were also housed in more desirable areas, further away from homeless hostels and services, or high-density social housing.

In sharp contrast, the 'severely disadvantaged' (see section 7.3.4) and the 'ageing drinkers' (see section 7.3.3) faced the greatest challenges in separating from these networks. Apart from Liam, all of these individuals were housed in locations that were close to homeless hostels or high-density social housing. Consequently, their neighbours experienced similar needs to them, and hindered their capacity to make choices in line with their desired outcomes. In addition, none of these participants could reasonably access positive and supportive relationships with families. All had broken ties with families in the past, often because of abusive or traumatic situations.

Once they entered participants' tenancies, qualitative accounts highlighted how these associates limited participants control over their housing, and behaviour. These differences had significant consequences for participants' actions. As highlighted in section 3.5.3, local social networks have a prominent role in influencing choices. The prominence of local social networks is also widely reported in recovery and desistance literature (Dingle et al., 2015; Topor et al., 2006). These networks have considerable influence over the social and moral norms displayed to

participants. In this study, these norms broadly consisted of either those experienced in a homeless setting, or those in keeping with 'positive and meaningful life'. As outlined in section 3.2, recovery is about overcoming needs, and pursuing a positive and meaningful life. 'Middle aged desisters' were surrounded by norms which largely encouraged both of these goals. Whereas 'severely disadvantaged' participants were surrounded by norms which guided choices towards familiar preferences that compounded their needs.

The difference in norms is better understood by considering the motivators each 'type' faced. Temptation to engage in substance use, and provocation to engage in violence were common throughout the experiences of 'severely disadvantaged', and to a lesser extent the 'ageing drinkers', and 'young and excluded'. As a result, they contributed to periods of relapse and prevented participants from pursuing capabilities that were in line with their personal priorities. Further, they encouraged greater emotional stress amongst these individuals, inhibiting their capacity for self-control (Wikström & Trieber, 2007).

On the other hand, 'Middle aged desisters' faced very different motivators from their families, and their neighbours. Their families and neighbours encouraged more controlled substance use as well as engagement in meaningful activities. These positive relationships also limited the emotional stress, reducing the desire to engage in substance use, and encouraging more deliberative choices in line with personal priorities.

Finally, the different orientation of these networks provided inequitable resources and opportunities to participants. Those who had access to positive and supportive social networks could benefit from the material resources, and social capital they offered. As demonstrated in the experiences of the 'middle aged desisters'; families and neighbours offered employment, help with repairs, and support with childcare. Other participants could not access these resources, and

instead had to rely on the HF service for support. The service remit is another key factor that disadvantaged those participants with more complex life histories.

8.4.4: The limits of a 'Signposting' Model

The HF service focused primarily on housing individuals, and offering support to help them maintain that tenancy. The service relied on wider stakeholders to provide other forms of support, enabled through a 'signposting' approach. This housing focused remit suited some 'types' more than others.

The housing related focus of the HF service provided an appropriate foundation for those with lower needs, but was not sufficient for those with more complex needs. In turn, treatment and support services seemed to give preference to those with less complex needs.

'Middle aged desisters' needs were not solely consigned to housing. However, after being given the opportunity and foundation provided by independent housing, they were able to draw upon wider resources to make choices in line with their personal priorities. Their mental health and substance use needs were less severe, and they were able to access appropriate support to deal with these issues, through traditional channels. In turn, they commonly described their issues as being related to moral guilt about the way their life had gone. Independent housing allowed the opportunity to return to the more 'normal' life they had previously experienced.

'Severely Disadvantaged' participants had extremely complex mental health needs, and engaged in poly drug use, each of which were underpinned by profound and severe trauma, often in childhood. Section 3.5.2 outlines how such experiences can cause more deeply ingrained mental health and substance misuse issues. As a result, these individuals tested the service's ability to gain access to wider forms of support, associated to these other needs. Each of these individuals expressed a desire for support and treatment to deal with their needs, but were unable to access

it. They were confronted with familiar barriers around 'dual diagnosis', compounded by the restricted capacity of mental health services in particular (see section 2.8). For these participants, the 'choice and control' offered by the HF service did not extend to these other essential forms of treatment and support. Instead, these services continued to operate under conditions which excluded clients with the most complex needs. Given the complexity of their needs, it is highly unlikely that any of these individuals will be able to progress without such support.

'Ageing drinkers' and 'young and excluded' participants self-excluded from wider support. Individuals in each other 'type' had less complex needs than 'severely disadvantaged' participants did. The 'young and excluded' faced problems with impulse and self-control. These individuals did not express a desire to access wider support to address their needs. The 'ageing drinkers' did not express this desire either, but more due to a lack of hope that change was possible. Each of these cohorts 'choose' not to engage in support, and in line with the 'separation of housing and treatment' (see section 2.7.4), should not be forced to do so. However, the ACT approach (section 2.5) may provide a means of assertively offering this form of support, by bringing it to clients. In turn, ACT may provide a 'fresh approach' which brings together health and social agencies together in ways personalised to the individual, as suggested by Dame Carol Black (2016).

The co-located multi-disciplinary design of the ACT approach does seem to provide solutions the issues experienced with the ICM approach in Newcastle; namely exclusion on the grounds of conditions (dual diagnosis) and reduced capacity due to funding issues. ACT brings essential treatment and support for substance use and mental health under the HF philosophy and provides dedicated funding. Findings from this study would suggest that costs can be kept down by targeting ACT to only those with the highest needs (Aubry et al., 2015; Tsemberis, 2013).

In PHF, variations in clients' support needs are met through a tiered model of support (see section 2.5). However, apart from larger implementations such as those in Denmark, France, and Canada, this tiered offer has not been incorporated in other HF services. In England (and Newcastle more specifically), support is not delivered in a tiered nature. Instead, the flexibility required to tailor support to the individual is achieved through a single case manager, who, through a client centred approach signposts and support clients to other services and forms of treatment (Bretherton & Pleace, 2015)(see section 2.8). As a result, the barriers presented here may be generalised on a national level, whilst taking account of differences across regional and local contexts.

For those participants who did begin to address their needs, fundamental barriers still remained, which prevented them from achieving their vision of a positive and meaningful life. Johnny gained employment on an informal basis with his brother, but struggled to find any formal employment during the study period. He also faced significant challenges with his benefit payments, being sanctioned. Joseph, who represented an anomaly amongst 'ageing drinkers' by experiencing a positive trajectory was also sanctioned. Although this did enable a separation from subjectively negative associations who frequented his flat in order to financially exploit him, it would have also led to his eviction without financial support from the HF service. For each participant, these sanctions led to a reduction in resources available to make subjectively beneficial choices towards social inclusion (see section 2.8.1).

These examples are few and nuanced but do suggest that even after needs are addressed HF clients are still likely to face significant barriers to wider social and economic inclusion. Although specific to a UK context, they echo findings of Henwood et al., (2015) who identified significant barriers to actualising longer-term goals, such as employment. As outlined in section, 3.5.3 employers are

gatekeepers of wider social and economic inclusion. In order for participants to achieve these outcomes, change is required beyond immediate service provision. There is a need to acknowledge that people with long histories of homelessness, and complex needs, cannot be expected to undertake systematic job search activities. As long as employment acts as a central gateway for economic and social inclusion, these individuals are unlikely to achieve either. Consequently, the findings of this study support Dame Carol Black's review (2016) which suggested that employment agencies must work more closely with health and social agencies.

8.5: Choice and Control: Humane, but effective?

Rather than offering choice itself, HF offers clients' resources (e.g. a flat), and opportunities (autonomy over behaviour and 'right to refuse' support) to utilise choice. HF also aims to shift the social norms that surround clients through independent housing, and community based support, away from the negative influence of congregate living situations, which contain high numbers of individuals with similar needs and behavioural preferences.

The service is client centred, and 'choice' is the mechanism by which clients are able to pursue wider, recovery-orientated outcomes. The choices that clients make are intertemporal, with actions which have consequences that play out over time, affecting clients' ability to achieve these outcomes.

In this regard, participants have variable capacities, resulting from a situational interaction between their personal 'needs', 'capabilities', and associated 'preferences', as well as the 'norms', 'opportunities', and 'resources' available to them in their environment.

This study identified relevant 'personal' and 'environmental' factors and explored them over time. In doing so, a typology of participants' life histories was

created, representative of the key strengths and challenges they faced in making these choices. The key environmental factors were also identified and drawn into key themes of housing, local social networks, service remit, and service stakeholders, each of which affected the 'norms', 'opportunities' and 'resources' of clients.

These were compared with participants' 'outcome trajectories' and were found to be predictive of participants' capacity to use 'choice and control' to pursue recovery orientated outcomes.

In contrast to the paternalistic linear models of support, guided by a 'treatment first' philosophy, the 'choice and control' offered by HF is a more humane approach to support MEH adults. These individuals have been excluded repeatedly over their life course, compounding needs that have often developed early in life. In line with other studies, HF was effective in housing these individuals, helping them to retain accommodation. Participants also perceived a much higher degree of choice and control in HF, in comparison with congregate homeless accommodation.

Therefore, it is important to clarify that evidence from this study does suggest that HF is a more humane and effective means of supporting MEH adults to access and retain accommodation. There was no clear evidence to suggest that HF is a 'liberalist method of controlling subjects' (Löfstrand & Juhila, 2012). All participants ended up more satisfied and perceived themselves to have an opportunity for change, and a greater sense of control over their lives in a HF tenancy than in congregate homeless accommodation, where many felt 'trapped'. In turn, almost all participants had priority outcomes that fitted closely with service outcomes and wider definitions of 'success' in recovery and desistance literature.

However, this thesis was primarily concerned with whether 'choice and control' is an effective mechanism enabling the achievement of 'successful'

outcomes in HF, beyond housing. The answer within the social, political, and economic context of this implementation is *it depends*.

There were clear 'success' stories amongst the 'Middle Aged Desisters' with some achieving their ultimate priorities within the relatively short window for which the study followed them. For these individuals, the opportunity and foundation provided by independent housing, combined with 'choice and control' over their housing, support and behaviour allowed them to achieve these priorities. However, for many 'ageing drinkers' and 'severely disadvantaged' participants, little changed.

The extent to which the HF service could enable participants to move towards a positive trajectory was closely related to the complexity of the individual's life history. Those participants with less severe needs and more capabilities were more able to take advantage of the opportunity provided by the HF service. Participants with more complex needs continued to face negatively orientated social networks, and were excluded from services essential to recovery. They have also lacked the opportunities in their lives to develop capabilities relevant to achieving greater social and economic inclusion, a key aspect of recovery (Anthony, 1993; White, 2007).

Ultimately, the findings of this study emphasise that simply 'offering' choice and control to participants is not enough. Any HF implementation needs to take account of participants' needs, capabilities and behavioural preferences to understand their 'starting point' when entering the HF service. Those with the most challenging life histories required a more intensive and flexible approach.

Larger scale, nationally funded implementations offer such an approach, providing ACT teams for those with higher needs. However, Canadian studies demonstrates that even ACT teams alone may not be sufficient (Nelson et al., 2015). Therefore, there is also a need for broader recognition that these individuals have faced lifetimes of exclusion and disadvantage, which have left many with few

opportunities, resources or capabilities to pursue the life they wish to lead, and we wish them to lead. Consequently, many positive outcomes will not be forthcoming for many years to come, if at all. As a result, it is important that HF is not seen as a panacea for those who have experienced lifetimes of disadvantage and exclusion. For those already experiencing MEH, greater fidelity to the original model brings better outcomes. More HF services would be an important part of preventing the detrimental impact of congregate accommodation. However, simply providing housing, first, is not sufficient. This is particularly true in an English context where HF is less developed, and has been implemented without the same rigour as the original implementation.

HF shifts treatment and support from congregate settings to the community and aims to bring wider social and economic inclusion. Any implementation of the model must also pay particular attention to the communities clients are being moved into, as well as the importance of wider service stakeholders such as landlords and treatment providers, who can facilitate or hinder participants capacity for choice and control, as well as their trajectories significantly.

Although the original implementation sourced housing from the PRS, other implementations have demonstrated that housing can be sourced through other tenures (Busch-Geertsema, 2013). Findings from this study demonstrate that MEH adults face significant barriers to choice over housing options in the PRS. They also demonstrate the importance of sourcing housing from a range of tenures to ensure that clients are not located in the same areas from which their needs emerged, or which are close to homeless services.

As noted in the introduction to this thesis, HF is based on the premise that if someone is homeless, they are given a house. To this point, HF literature has been primarily concerned with this transition out of homelessness. However, to help the model develop, more detailed critical qualitative enquiry is required into how

principles are operationalised in particular contexts. Without critical interrogation, these principles risk becoming nothing more than nice sounding words. There is increasing evidence of this type of research, but more is required.

This thesis has shown that through critical enquiry, applied in a particular context it is possible to highlight the key facilitators and barriers of choice and control for clients, and how these manifest in unequal outcomes. In doing so, the thesis has looked beyond the transition out of homelessness, and offered insight into how the model can support the transition out of disadvantage more broadly. In particular, this study has demonstrated that those with the longest and most complex histories of social and economic exclusion require additional consideration in HF. Essentially, they require more support, and resources to meet their more 'multiple and complex' needs, and to overcome deficits in their capabilities for living a positive and meaningful life.

Lived Experiences of ‘Choice’, ‘Control’, and ‘Success’ in Housing First

Christopher N Parker

A thesis submitted in partial fulfilment
of the requirement for the award for
the degree of Doctor of Philosophy at
the University of Northumbria at
Newcastle

Research undertaken in the Faculty of
Arts, Design and Social Sciences

2017

Volume 2 of 2

Contents

Appendix A.....	333
A.1: References	334
Appendix B.....	366
B.1.1: Example of Domains and Composite Measures for Outcome Measurement in Housing First	367
B.1.2: Example of Domains and Composite Measures used in Life History Categorisation	375
B.2: Personal Capacity for Choice and Control: Analysis and Discussion of Participant ‘Needs’ and ‘Capabilities’	380
B.2.1: The Extent and Severity of ‘Needs’ in Participant’s Life Histories	380
B.2.2: The Extent and Mastery of ‘Capabilities’ in Participant’s Life Histories	397
B.3: Situational Vignettes	404
B.3.1: Joel – ‘Police at the Door’	404
B.3.2: Bev – ‘Splitting up with partner’	408
Appendix C.....	412
C.1: ‘Easy Read’ Participant Information Form	413
C.2: Client Participant Topic Guides.....	419
C.2.1 : Wave 1 – Client Participant Topic Guide	419
C.2.2 : Wave 2 – Client Participant Topic Guide	426
C.2.3 : Wave 3 – Client Participant Topic Guide	433
C.2.4: ‘Life History’ Interview – Client Participant Topic Guide.....	442
C.3: Stakeholder Participant Topic Guides	448
C.3.1: Wave 1 – Case/Service Manager Topic Guides.....	448
C.3.2: Wave 3 – Case/ Service Manager Topic Guides.....	454
C.3.3: Wave 3 - Commissioner Topic Guide	459

Figures and Tables

Figure

<i>Figure B.1: Situational Analysis of Key Turning Point for Joel</i>	407
<i>Figure B.2: Situational Analysis of Key Turning Point for Bev</i>	410

Table

<i>Table B.1: Domains and Composite Measures for Outcome Measurement in Housing First (Arnie)</i>	367 - 374
<i>Table B.2: Domains and Composite Measures used in Life History Categorisation (Lyla)</i>	375 - 379
<i>Table B.3: Substance Type and Number of Substances around which issues have subjectively developed</i>	383 - 384
<i>Table B.4: Substance Use Issues described at Wave One</i>	385
<i>Table B.5: Self-Reported Mental Health Issues for which participants had been diagnosed</i>	388
<i>Table B.6: Incidence of 'Street Culture Activities' in Participants Life Histories</i>	393 - 394
<i>Table B.7: Participant's experience of tenancy sustainment</i>	401

Appendix A

A.1: References

A.1: References

- Anderson, I. (2003). *Synthesizing homelessness research: trends, lessons and prospects*. Journal of Community & Applied Social Psychology, 13(2): 197-205.
- Anthony, W. A. (1993). *Recovery from mental illness: The guiding vision of the mental health service system in the 1990s*. Psychosocial Rehabilitation Journal, 16(4): 11-23.
- Atherton, I. & McNaughton-Nicholls, C. (2008). *'Housing First' as a means of addressing multiple needs and homelessness*. European Journal of Homelessness, 2: 289-303.
- Aubry, T., Nelson, G., & Tsemberis, S. (2015). *Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research and Findings from the at Home—Chez soi Demonstration Project*. The Canadian Journal of Psychiatry, 60(11): 467-474.
- Bacon, N., Brophy, M., Mguni, N., Mulgan, G., Shandro, A. (2010). *The State of Happiness: Can Public Policy Shape People's Wellbeing and Resilience?* London, The Young Foundation.
- Baker, T. & Evans, J. (2016). *'Housing First' and the Changing Terrains of Homeless Governance*. Geography Compass, 10(1): 25-41.
- Barnes, M. & Prior, D. (1995). *Spoilt for choice? How consumerism can disempower public service users*. Public Money & Management, 15(3): 53-58.
- Baumeister, D., Tojo, L.M., & Tracy, D.K. (2015). *Legal highs: staying on top of the flood of novel psychoactive substances*. Therapeutic advances in psychopharmacology, 5(2): 97-132.
- Baxter, K., & Glendinning, C. (2013). *The role of emotions in the process of making choices about welfare services: the experiences of disabled people in England*. Social Policy and Society, 12(3): 439-450.

- Beatty, C., & Fothergill, S. (2014). *The local and regional impact of the UK's welfare reforms*. Cambridge Journal of Regions, Economy and Society, 7(1): 63-79.
- Bengtsson, B. & Hertting, N. (2014). *Generalization by mechanism: Thin rationality and ideal-type analysis in case study research*. Philosophy of the social sciences, 44(6): 707-732.
- Benjaminsen, L. (2013). *Policy review up-date: Results from the Housing First based Danish homelessness strategy*. European Journal of Homelessness, 7(2): 109-131
- Benjaminsen, L., Dyrby, T.M., Enemark, M.H., Thomsen, M.T., Dalum, H.S., & Vinther, U.L. (2017). *Housing First I Danmark: Evaluerende Af Implementerings-og Forankringsprojektet I 24 kommuner*. Copenhagen. Sfi-Det Nationale Forskningscenter for Valfærd.
- Bentley, J. & Thacker, P. (2004). *The influence of risk and monetary payment on the research participation decision making process*. Journal of Medical Ethics, 30(3): 293-298.
- Bernad, R., Yuncal, R., & Panadero, S. (2016). *Introducing the Housing First Model in Spain: First Results of the Habitat Programme*. European Journal of Homelessness, 10(1): 53-82.
- Berns, G. S., Laibson, D., & Loewenstein, G. (2007). *Intertemporal choice – toward an integrative framework*. Trends in Cognitive Sciences, 11(11): 482-488.
- Black, C. D. (2016). *Drug and Alcohol addiction, and obesity: Effects on employment outcomes*. Independent Review. London. Department for Communities and Local Government. Retrieved from:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573892/employment-outcomes-of-drug-or-alcohol-addiction-and-obesity-print.PDF
- Bond, G. R., Drake, R. E., Mueser, K. T., & Latimer, E. (2001). *Assertive community treatment for people with severe mental illness*. Disease Management and Health Outcomes, 9(3): 141-159.

- Bonney, S. & Stickley, T. (2008). *Recovery and mental health: a review of the British literature*. Journal of psychiatric and mental health nursing, 15(2): 140-153.
- Bourdieu, P. (1986). *The forms of capital*. In J. Richardson (Ed.) Handbook of Theory and Research for the Sociology of Education, New York, Greenwood, 241-258.
- Bowpitt, G., Dwyer, P., Sundin, E., Weinstein, M. (2011). *The support priorities of multiply excluded homeless people and their compatibility with support agency agendas-new research into multiple exclusion homelessness*. Housing, Care and Support. 14(1): 31-32.
- Bowpitt, G., Dwyer, P., Sundin, E., & Weinstein, M. (2014). *Places of Sanctuary for 'the Undeserving'? Homeless People's Day Centres and the Problem of Conditionality*. British Journal of Social Work, 44(5): 1251-1267.
- Boyce, I. (2006). *Neighbourliness and privacy on a low income estate*. Sociological Research Online, 11(3).
- Bradshaw, W., Armour, M.P., & Roseborough, D. (2007). *Finding a place in the world: The experience of recovery from severe mental illness*. Qualitative Social Work 6(1): 27-47.
- Bradshaw, J., Glendinning, C., Maynard, A., & Bennett, F. (2015). *Thematic Report on Social Investment in UK*. European Social Policy Network.
- Bretherton, J. & Pleace, N. (2015). *Housing First in England: An Evaluation of Nine Services*. York, Centre for Housing Policy. Retrieved from:
<https://www.york.ac.uk/media/chp/documents/2015/Housing%20First%20England%20Report%20February%202015.pdf>
- Bryman, A. (2012). *Social research methods*. Oxford, Oxford University Press.
- Bryman, A. (2015). *Social research methods*, Oxford, Oxford University Press.
- Buchanan, J. (2004). *Tackling problem drug use: a new conceptual framework*, Social Work in Mental Health, 2(3): 117–138.

- Buchanan, J. & Young, L. (2000). *The war on drugs – a war on drug users?* *Drugs: Education, Prevention and Policy*, 17(4): 409–422.
- Busch-Geertsema, V. (2002). *When Homeless People Are Allowed to Decide by Themselves. Rehousing Homeless People in Germany*. *European Journal of Social Work*, 5(1): 5-19.
- Busch-Geertsema, V. (2013). *Housing First Europe Final Report*. Bremen, Housing First Europe.
- Cabinet Office (2007). *Reaching Out: Progress on Social Exclusion*, London, HM Government.
- Cameron, A. (2016). *What have we learnt about joint working between health and social care?* *Public Money & Management*, 36(1): 7-14.
- Cameron, A., Lart, R., Bostock, L., & Coomber, C. (2014). *Factors that promote and hinder joint and integrated working between health and social care services: a review of research literature*. *Health & Social Care in the Community*, 22(3): 225-233.
- Carling, P.J. (1995). *Return to community: Building support systems for people with psychiatric disabilities*. New York, Guilford Press.
- Caton, C. L., Wilkins, C., & Anderson, J. (2007). *People who experience long-term homelessness: characteristics and interventions*. Paper presented at the 'Toward Understanding Homelessness'. The 2007 National Symposium on Homelessness Research.
- Centre for Social Justice (2017). *Housing First: Housing Led solutions to rough sleeping and homelessness*. London, Centre for Social Justice. Retrieved from: http://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf
- Clapham, D. (2003). *Pathways approaches to homelessness research*. *Journal of Community & Applied Social Psychology*, 13(2): 119-127.

- Clapham, D. (2005). *The meaning of housing: a pathways approach*. Bristol, Policy Press.
- Clapham, D. (2010). *Happiness, well-being and housing policy*. *Policy & Politics*, 38(2): 253-267.
- Clapham, D. (2011). *The embodied use of the material home: An affordance approach*. *Housing, Theory and Society*, 28(4): 360-376.
- Clarke, J., Newman, J., & Westmarland, L. (2008). *The Antagonisms of Choice: New Labour and the reform of public services*. *Social Policy and Society*, 7(2): 245-253.
- Cloke, P., Cooke, P., Cursons, J., Milbourne, P., Widdowfield, R. (2000). Ethics, reflexivity, and research: encounters with homeless people. *Ethics, Place & Environment*. 3(2): 133 – 154
- Cloke, P., May, J., & Johnsen, S. (2010). *Swept up Lives: Re-envisioning the homeless city*, Chichester, John Wiley & Sons.
- Coles, J. & Mudaly, N. (2010). *Staying safe: Strategies for qualitative child abuse researchers*. *Child Abuse Review*, 19(1): 56 – 69.
- Coles, J., Astbury, J., Dartnall, E., Limjerwala, S., (2014). *A qualitative exploration of researcher trauma and researchers' responses to investigating sexual violence*. *Violence Against Women*. 20(1): 95-117.
- Collier, R. B. & Collier, D. (1991). *Shaping the Political Arena : Critical Junctures, the Labor Movement and Regime Dynamics in Latin America*. Princeton, Princeton University Press.
- Cornes, M., Joly, L., Manthorpe, J., O'Halloran, S., & Smyth, R. (2011). *Working together to address multiple exclusion homelessness*. *Social Policy and Society*, 10(4): 513-522.
- Cornes, M., Manthorpe, J., Joly, L., & O'Halloran, S. (2014). *Reconciling recovery, personalisation and Housing First: integrating practice and outcome in the field of*

multiple exclusion homelessness. Health & Social Care in the Community, 22(2), 134-143.

Crang, Mike. (2002). *Qualitative methods: The new orthodoxy?* Progress in Human Geography, 26(5): 647–55.

Culhane, D. P. (2008). *The cost of homelessness: A perspective from the United States*. European Journal of Homelessness, 2(1): 97-114.

Culhane, D. P. & S. Metraux (2008). *Rearranging the deck chairs or reallocating the lifeboats? Homelessness assistance and its alternatives*. Journal of the American Planning Association, 74(1): 111-121.

Cunningham, J. A., Sobell, L. C., Sobell, M. B., Agrawal, S., & Toneatto, T. (1993). *Barriers to treatment: Why alcohol and drug abusers delay or never seek treatment*. Addictive behaviors, 18(3): 347-353.

Davidson, L. (2005). *Recovery, self management and the expert patient—changing the culture of mental health from a UK perspective*. Journal of Mental Health, 14(1): 25-35.

Davidson, L. & White, W. (2007). *The concept of recovery as an organizing principle for integrating mental health and addiction services*. The Journal of Behavioral Health Services & Research, 34(2): 109-120.

Davis, M. (1990). *City of quartz: excavating the future in Los Angeles*. London, Verso.

Dear, M. J., & Wolch, J. R. (1987). *Landscapes of despair: From deinstitutionalization to homelessness*. Cambridge, Polity Press.

Department for Work & Pensions (DWP)(2017). *Improving Lives: Helping Workless Families Analysis and Research Pack*. London. DWP. Retrieved from:

<https://www.gov.uk/government/publications/improving-lives-helping-workless-families-evidence-base>

- DeVerteuil, G. (2004). *Systematic inquiry into barriers to researcher access: Evidence from a homeless shelter*. The Professional Geographer, 56(3) 372 – 380.
- Diener, E., Emmons, R., Larsen, R., & Griffin, S. (1985). *The satisfaction with life scale*. Journal of personality assessment, 49(1): 71-75.
- Dingle, G. A., Stark, C., Cruwys, T., & Best, D. (2015). *Breaking good: Breaking ties with social groups may be good for recovery from substance misuse*. British Journal of Social Psychology, 54(2): 236-254.
- Dolan, P., Layard, R., & Metcalfe, R. (2011). *Measuring subjective well-being for public policy*. Special Paper No.23, Centre for Economic Performance.
- Dolan, P., Peasgood, T., & White, M. (2008). *Do we really know what makes us happy? A review of the economic literature on the factors associated with subjective well-being*. Journal of economic psychology, 29(1): 94-122.
- Drake, R. E., Mueser, K., Brunette, M., & McHugo, G. (2004). *A review of treatments for people with severe mental illnesses and co-occurring substance use disorders*. Psychiatric Rehabilitation Journal, 27(4): 360-374.
- Dworkin, R. (1981). *What is equality? Part 2: Equality of resources*. Philosophy & Public Affairs, 10(4): 283-345.
- Dwyer, P. (2004). *Creeping conditionality in the UK: from welfare rights to conditional entitlements?* The Canadian Journal of Sociology, 29(2): 265-287.
- Dwyer, P. (2010). *Understanding social citizenship: Themes and perspectives for policy and practice*. Bristol, Policy press.
- Dwyer, P., Bowpitt, G., Sundin, E., & Weinstein, M. (2014). *Rights, responsibilities and refusals: Homelessness policy and the exclusion of single homeless people with complex needs*. Critical Social Policy, 35(1): 3-23.
- Dwyer, P., & Wright, S. (2014). *Universal credit, ubiquitous conditionality and its implications for social citizenship*. Journal of Poverty and Social Justice, 22(1): 27-35.

- Ellison, M. L., Belanger, L., Niles, B., Evans, L., & Bauer, M. (2016). *Explication and Definition of Mental Health Recovery: A Systematic Review*. Administration and Policy in Mental Health and Mental Health Services Research, 1-12.
- Elster, J. (1983). *Sour Grapes: Studies in the Subversion of Rationality*. Cambridge, MA, Cambridge University Press.
- Elster, J. (1991). *Rationality and Social norms*. European Journal of Sociology, 32(1): 109-129.
- Elster, J. (1996). *Rationality and the Emotions*. The Economic Journal, 106(438): 1386-1397.
- Elster, J. (2009). *Social norms and the explanation of behavior*. In Hedström, P. and Bearman, P. (eds) The Oxford Handbook of Analytical Sociology, Oxford, Oxford University Press, 195 - 217.
- EnglandKennedy, E. S., & Horton, S. (2011). *Everything that I thought that they would be, they weren't: Family systems as support and impediment to recovery*. Social Science & Medicine, 73(8): 1222-1229.
- Ensign, J. & Ammerman, S. (2008) *Ethical Issues in research with homeless youths*. Journal of Advanced Nursing, 62(3): 365-372.
- Eklund, M., Erlandsson, L. K., Hagell, P. (2012) *Psychometric properties of a Swedish version of the Pearlin Mastery Scale in people with mental illness and healthy people*. Nordic Journal of Psychiatry, 66(6): 380 – 388.
- Esping-Andersen, G. (2013). *The Three Worlds of Welfare Capitalism*: Chichester. John Wiley & Sons.
- Evans, G. W., Wells, N., Moch, A. (2003). *Housing and Mental Health: A review of the evidence and a methodological and conceptual critique*. Journal of Social Issues, 59(3): 475-500.
- Farrington, D. P. (2007). *Advancing knowledge about desistance*. Journal of Contemporary Criminal Justice, 23(1): 125-134.

- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study*. American journal of preventive medicine, 14(4): 245-258.
- Fitzpatrick, S. (2005). *Explaining homelessness: a critical realist perspective*. Housing, Theory and Society, 22(1): 1-17.
- Fitzpatrick, S., Johnsen, S., & White, M. (2011). *Multiple exclusion homelessness in the UK: key patterns and intersections*. Social Policy and Society, 10(04): 501-512.
- Fitzpatrick, S., Bramley, G. & Johnsen, S. (2012). *Pathways into multiple exclusion homelessness in seven UK cities*. Urban Studies, 50(1): 148-168
- Fitzpatrick, S., & Bramley, G. (2015). *Hard Edges: Mapping Severe and Multiple Exclusion*. Lankelly Chase.
- Fitzpatrick, S., Pawson, H., Bramley, G., & Wilcox, S. (2011). *The Homelessness Monitor: England 2011*. London. Crisis.
- Fitzpatrick, S., Pawson, H., Bramley, G., Wilcox, S., & Watts., B (2017) *Homeless Monitor: England 2017*. Crisis/ Joseph Rowntree Foundation.
- Fitzpatrick, S., & Stephens, M. (2014). *Welfare regimes, social values and homelessness: Comparing responses to marginalised groups in six European countries*. Housing Studies, 29(2): 215-234.
- Foege, W. H. (1998). *Adverse childhood experiences: A public health perspective*. American Journal of Preventative Medicine, 14(4): 354-355.
- France, A., Bendelow, G. & Williams, S. (2000) *A "Risky" Business: Researching the Health Beliefs of Children and Young People*, in A. Lewis & G. Lindsay (eds) *Researching Children's Perspectives*, Buckingham, Open University Press, 150–62.
- Frazer, E. & Lacey, N. (1994). *The Politics of Community: A Feminist Critique of the Liberal-Communitarian Debate*. Cambridge Law Journal, 53: 619-619.

- Frijda, N. H. (1986). *The Emotions: Studies in Emotion and Social Interaction*. Cambridge. Cambridge University Press.
- Freese, J. (2008). *Genetics and the Social Science Explanation of Individual Outcomes*. American Journal of Sociology, 114(1): 1-35.
- Freese, J. (2009). *Preferences* in Hedström, P. and Bearman, P., *The Oxford Handbook of Analytical Sociology*, Oxford, Oxford University Press, 94-114.
- Gallupe, O., & Baron, S. W. (2010). *Morality, Self-control, Deterrence, and Drug Use: Street Youths and Situational Action Theory*. Crime & Delinquency, 60(2): 284-305.
- George, A. L. & McKeown, T. J. (1985). *Case studies and theories of organisational decision making*, in Sproull, L. & Larkey, V. (eds) *Advances in Information Processing In Organisations*, 2, Santa Barbara, JAI Press: 21-58.
- Gibb, K., Sprigings, N., Wright, S., McNulty, D. (2014). *Evidence Review of the Impacts of UK Welfare Reform Affecting Housing in Scotland*. Edinburgh, Scottish Government.
- Giddens, A. (1991). *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Stanford, Stanford University Press.
- Gieryn, T. (2002) *What buildings do*. Theory and Society, 31: 35-74.
- Gilmer, T. P., Stefancic, A., Sklar, M., & Tsemberis, S. (2013). *Development and Validation of a Housing First Fidelity Survey*. Psychiatric Services, 64(9): 911-914.
- Gintis, H. (2000). *Strong Reciprocity and Human Sociality*. Journal of Theoretical Biology, 206(2), 169-179.
- Greve, B. (2011). *Choice: Challenges and Perspectives for the European Welfare States*. Chichester, John Wiley & Sons.
- Goffman, E. (1978). *The presentation of self in everyday life*, New York, Random House.

- Goldstein, D. G. (2009). *Heuristics* in Hedström, P. and Bearman, P. (eds), in *The Oxford Handbook of Analytical Sociology*, Oxford, Oxford University Press, 140-167.
- Goodman, L. A., Saxe, L., & Harvey, M. (1991). *Homelessness as Psychological Trauma: Broadening perspectives*. *American Psychologist*, 46(11): 1219-1225.
- Gordon, D., Adelman, L., Bradshaw, J., Levitas, R., Middleton, S., Pantazis, C., Patsios, D., Payne, S., Townsend, P. (2000). *Poverty and social exclusion in Britain*. York. Joseph Rowntree Foundation.
- Granovetter, M. (1985). *Economic Action and Social Structure: The Problem of Embeddedness*. *American Journal of Sociology*, 91(3): 481-510.
- Grant, R. W. (2011). *Strings Attached: Untangling the ethics of Incentives*. Princeton, Princeton University Press.
- Grant, R. W. and Sugarman, J. (2004). *Ethics in human subjects research: do incentives matter?* *Journal of Medicine and Philosophy*, 29(6): 717-738.
- Greener, I. (2008). *Choice and Voice: A Review*. *Social Policy and Society*, 7(2): 255-265.
- Greener, I., Powell, M., & Simmons, R. (2009). *The Consumer in Public Services: Choice, Values and Difference*, Bristol, Policy Press.
- Greener, I., & Powell, M. (2009). *The other Le Grand? Evaluating the 'other Invisible Hand' in Welfare Services in England*. *Social Policy & Administration*, 43(6): 557-570.
- Greenwood, R. M., Schaefer-McDaniel, N., Winkel, G., Tsemberis, S. (2005). *Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness*. *American Journal of Community Psychology*, 36(3-4): 223-238.
- Greenwood, R. M., Stefancic, A., Tsemberis, S., & Busch-Geertsema, V. (2013). *Implementations of Housing First in Europe: Successes and Challenges in*

Maintaining Model Fidelity. American Journal of Psychiatric Rehabilitation, 16(4): 290-312.

Gregg, P., Jerrim, J., Macmillan, L., & Shure, N. (2017) *Children in jobless households across Europe: Evidence on the association with medium and long term outcomes*. Institute of Education. Retrieved from:
<http://repec.ioe.ac.uk/REPEc/pdf/qsswp1705.pdf>

Groshkova, T., & Best, D. (2011). *The Evolution of a UK Evidence Base for Substance Misuse Recovery*. Journal of Groups in Addiction & Recovery, 6(1-2), 20-37.

Harding, J., Irving, A., & Whowell, M.(2011). *Homelessness, Pathways to Exclusion and Opportunities for Intervention*. Newcastle-upon-Tyne, Northumbria Graphics, Arts and Social Sciences Academic Press.

Harding, J., Irving, A., Fitzpatrick, S., & Pawson, H. (2013). *Evaluation of Newcastle's 'Cooperative' Approach to the Prevention and Management of Homelessness in light of Changing Government Policy*. Newcastle-upon-Tyne, Newcastle City Council. Retrieved from:
https://www.newcastle.gov.uk/sites/default/files/wwwfileroot/housing/evaluation_of_newcastles_co-operative_approach_executive_summary.pdf

Harold, G., Acquah, D., Sellers, R., & Chowdry, H. (2016) *What works to Enhance Inter-parental Relationships and Improve Outcomes for Children*. London, Department for Work and Pensions. Retrieved from:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509368/what-works-to-enhance-inter-parental-relationships.pdf

Hedström, P. (2005). *Dissecting the Social: On the Principles of Analytical Sociology*, Cambridge, Cambridge University Press.

Hedström, P. and Bearman, P. (2009). *The Oxford Handbook of Analytical Sociology*, Oxford, Oxford University Press.

- Helfrich, C. A. and Chan, D. V. (2013). *Changes in Self-Identified Priorities, Competencies, and Values of Recently Homeless Adults with Psychiatric Disabilities*. American Journal of Psychiatric Rehabilitation, 16(1): 22-49.
- Henwood, B. F., Derejko, K.S., Couture, J., and Padgett, D.K. (2015). *Maslow and Mental Health Recovery: A Comparative Study of Homeless Programs for Adults with Serious Mental Illness*. Administration and Policy in Mental Health and Mental Health Services Research, 42(2): 220-228.
- Herring, C. (2014) *The New Logics of Homeless Seclusion: Homeless Encampments in America's West Coast Cities*. City and Community, 13(4): 285-309.
- Hogg, M. A. (2006). *Social Identity Theory*. In Burke (ed.) Contemporary Social Psychological Theories, 111-136
- Holland, J., & Thomson, R. (2009). *Gaining perspective on Choice and Fate: Revisiting Critical Moments*. European Societies, 11(3): 451-469.
- Homeless Link (2016) *Housing First England: The Principles*. Retrieved from: http://hfe.homeless.org.uk/sites/default/files/attachments/Housing%20First%20in%20England_The%20Principles.pdf
- House of Commons Library (HoC) (2017) *The Troubled Families Programme: England*. Briefing Paper. CBP 07585. London. House of Commons. Retrieved from: <http://researchbriefings.files.parliament.uk/documents/CBP-7585/CBP-7585.pdf>
- Housing First Belgium (2016) *Housing First Belgium Results* Retrieved from: <http://www.housingfirstbelgium.be/medias/files/housing-first-belgium-results-en.pdf>
- Hutz, C. & Koller, S. (1999) *Methodological and ethical issues in research with street children*. New Directions for Child and Adolescent Development, 85: 59 – 70.
- Johnsen, S. (2014). *Turning Point Scotland's Housing First Evaluation: The Final Report*. Scotland, Turning Point.

- Johnsen, S., & Teixeira, L. (2010). *Staircases, elevators and cycles of change: 'Housing first' and other housing models for Homeless people with Complex Support Needs*. Crisis, London.
- Johnsen, S. and Teixeira, L. (2012). 'Doing it already?': stakeholder perceptions of *Housing First in the UK*. *International Journal of Housing Policy*, 12(2): 183-203.
- Johnsen, S., Fitzpatrick, S., & Watts, B. (2014). *Conditionality Briefing: Homelessness and 'Street Culture'*. ESRC. Retrieved from:
http://www.welfareconditionality.ac.uk/wp-content/uploads/2014/09/Briefing_Homelessness_14.09.10_FINAL.pdf
- Johnsen, S. and Watts, B. (2014). *Homelessness and Poverty: Reviewing the Links*. Edinburgh, Heriot Watt University. Retrieved from:
<https://pureapps2.hw.ac.uk/ws/portalfiles/portal/7467281>
- Kahneman, D., & Tversky, A. (2000). *Choices, Values, and Frames*. Cambridge, Cambridge University Press.
- Kahneman, D., Wakker, P. P., & Sarin, R. (1997). *Back to Bentham? Explorations of Experienced Utility*. *The Quarterly Journal of Economics*, 112(2): 375-405.
- Kazemian, L. (2007). *Desistance from Crime: Theoretical, Empirical, Methodological, and Policy Considerations*. *Journal of Contemporary Criminal Justice*, 23(1): 5-27.
- Keat, R., Whiteley, N., & Abercrombie, N. (1994). *The Authority of the Consumer*, London. Routledge.
- Kemp, P. A., Neale, J., & Robertson, M. (2006). *Homelessness among Problem Drug Users: Prevalence, Risk factors and Trigger events*. *Health & Social Care in the Community*, 14(4): 319-328.
- Kertesz, S.G., Crouch, K., Milby, J.B., Cusimano, R. E., & Schumacher, J. E. (2009). *Housing First for Homeless Persons with Active Addiction: are we Overreaching?* *Milbank Quarterly*, 87(2): 495-534.

- Kertesz, S.G., & Weiner, S.J. (2009). *Housing the Chronically Homeless: high hopes, complex realities*. JAMA, 301(17): 1822-1824.
- Khan, S., & VanWynsberghe, R., (2008) *Cultivating the Under-Mined: Cross Case Analysis as Knowledge Mobilization*. Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 9(1), art.34.
- Kim, M. M., Ford, J., Howard. D.L., Bradford, D.W. (2010). *Assessing Trauma, Substance Abuse, and Mental Health in a sample of Homeless Men*. Health & Social Work 35(1): 39-48
- King, P. (2003). *Housing as a freedom right*. Housing Studies 18(5): 661-672.
- Kirk, D. S. (2012). *Residential Change as a Turning Point in the Life Course of Crime: Desistance or Temporary Cessation?* Criminology, 50(2): 329-358.
- Knutagård, M., & Kristiansen, A. (2013). *Not by the book: The Emergence and Translation of Housing First in Sweden*. European Journal of Homelessness, 7(1): 93-115.
- Kresky-Wolff, M., Larson, M. J., O'Brien, R. W., & McGraw, S. A. (2010). *Supportive housing approaches in the Collaborative Initiative to help end Chronic Homelessness (CICH)*. The Journal of Behavioral Health Services & Research, 37(2): 213-225.
- Kuhn, R. and Culhane, D. P. (1998). *Applying cluster analysis to test a typology of homelessness by pattern of Shelter utilization: Results from the analysis of administrative data*. American Journal of Community Psychology 26(2): 207-232.
- Kusenbach, M. (2003). *Street phenomenology the go-along as ethnographic research tool*. Ethnography 4(3): 455-485.
- Lamb, H. R. (1993). *Lessons learned from Deinstitutionalisation in the US*. The British Journal of Psychiatry, 162(5): 587-592.
- Laub, J. H. & Sampson, R. J. (1993). *Turning points in the Life Course: Why Change matters to the Study of Crime*. Criminology 31(3): 301-325.

- Laub, J. H. & Sampson, R. J. (2001). *Understanding Desistance from Crime*. Crime and Justice, 28: 1-69.
- Laudet, A. B., Magura, S., Vogel, H., Knight, E. (2000) Support, Mutual aid and recovery from dual diagnosis. Community Mental Health Journal. 36(5): 457-476.
- Laudet, A. B. & White, W. L. (2008). *Recovery capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users*. Substance Use & Misuse, 43(1): 27-54.
- Laudet, A. B. & White, W. L. (2010). *What are your priorities right now? Identifying service needs across recovery stages to inform service development*. Journal of Substance Abuse Treatment, 38(1): 51-59.
- Le Grand, J. (2005). *Inequality, Choice and Public Services*, Bristol, Polity Press.
- Le Grand, J. (2009). *The Other Invisible Hand: Delivering Public services through Choice and Competition*, Princeton, Princeton University Press.
- Little, D. (2012) Analytical Sociology and the rest of Sociology. Sociologica, 6(1).
- Liamputtong, P. (2006) Researching the Vulnerable: A guide to sensitive research methods. London, Sage.
- Löfstrand, C. H., & Juhila, K. (2012). *The Discourse of Consumer Choice in the Pathways Housing First Model*. European Journal of Homelessness, 6(2): 47-68
- Ly, A. and Latimer, E. (2015). *Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature*. The Canadian Journal of Psychiatry, 60(11): 475-487.
- MacDonald, R. and J. Marsh (2002). *Crossing the Rubicon: Youth transitions, Poverty, Drugs and Social Exclusion*, International Journal of Drug Policy 13(1): 27-38.
- Making Every Adult Matter (MEAM) (2009) *A Four-point Manifesto for Tackling Multiple Needs and Exclusions*, London, Making Every Adult Matter.

- Marshall, G.N. & Lang, E.L. (1990) Optimism, self mastery, and symptoms of depression in women professionals. *J Pers Soc Psychol*, 59: 132-139.
- Martins, P., Ornelas, J., & Silva, A. C. (2016). *The Role of Perceived Housing Quality and Perceived Choice to Recovery: An Ecological Perspective on a Housing First Program in Lisbon*. *Journal of Environmental Psychology*, 47: 44-52.
- Maruna, S. (2001). *Making Good: How Ex-Convicts Reform and Rebuild their Lives*, Washington, American Psychological Association.
- Maruna, S. (2015). *Qualitative Research, Theory Development, and Evidence-Based Corrections: Can Success Stories Be "Evidence"?* in Palacios, W. & Miller, J. (eds.) *Qualitative Research in Criminology: Advances in Criminological Theory*, 311-331.
- Maté, G. (2010). *In the Realm of Hungry Ghosts: Close Encounters with Addiction*. Toronto, Vintage Canada.
- Maté, G. (2012). *Addiction: Childhood Trauma, Stress and the Biology of Addiction*, *Journal of Restorative Medicine*, 1(1): 56-63.
- McCarthy, L. (2013). *Homelessness and Identity: A Critical Review of the Literature and Theory*. *People, Place & Policy Online*, 7(1): 46-58.
- McKay, M., Davis, M., & Fanning, P. (1983). *Messages: The communication skills book*. Oakland, New Harbinger.
- McLeod, J. (2003). *Why we interview now – reflexivity and perspective in a longitudinal study*. *International Journal of Social Research Methodology*, 6(3): 201-212.
- McNaughton Nicholls, C. (2009). *Agency, Transgression and the Causation of Homelessness: A Contextualised Rational Action Analysis*. *European Journal of Housing Policy*, 9(1): 69-84.
- McNaughton Nicholls, C. (2010). *Housing, Homelessness and Capabilities*, *Housing, Theory & Society* 27(1): 23-41.

- McNaughton Nicholls, C., & Atherton, I. (2011). *Housing First: Considering Components for Successful Resettlement of Homeless People with Multiple Needs*. *Housing Studies*, 26(5), 767-777.
- Merrill, B. and West, L. (2009). *Using Biographical Methods in Social Research*, London, Sage.
- Mezzina, R., Borg, M., Marin, I., Topor, A., & Sells, D. (2006). *The Social Nature of Recovery: Discussion and Implications for Practice*. *Archives of Andrology*, 9(1): 63-80.
- Miles, M. B., Huberman, M.A., & Saldana, J. (2013). *Qualitative Data Analysis: A Methods Sourcebook: 3rd Edition*, London, SAGE Publications.
- Misetics, B. (2013) *The Criminalisation of Homelessness in Hungary* in Jones, S. (ed.) *Mean Streets*, Brussels, FEANTSA.
- Mitchell, D. (1997). *The Annihilation of Space by Law: The Roots and Implications of Anti-Homeless Laws in the United States*. *Antipode*, 29(3): 303-335.
- Mitchell, D. (1998a). *Anti-Homeless Laws and Public Space: I. Begging and the first amendment*. *Urban Geography*, 19(1): 6-11.
- Mitchell, D. (1998b). *Anti-Homeless Laws and Public Space: II. Further Constitutional Issues*. *Urban Geography*, 19(2): 98-104.
- Neale, B. & Flowerdew, J. (2003). *Time, Texture and Childhood: The Contours of Longitudinal Qualitative Research*. *International Journal of Social Research Methodology* 6(3): 189-199.
- Neale, J. (1997). *Homelessness and Theory Reconsidered*. *Housing Studies* 12(1): 47-61.
- Neale, J., Tompkins, C., Finch, E., Marsden, J., Mitcheson, L., Rose, D., Wykes, T., & Strang, J. (2014). *"You're all going to hate the word 'recovery' by the end of this": Service Users' Views of Measuring Addiction Recovery*. *Drugs: Education, Prevention and Policy*, 22(1): 26-34.

Nelson, G., Aubry, T., & Lafrance, A. (2007). *A Review of the Literature on the Effectiveness of Housing and Support, Assertive Community Treatment, and Intensive Case Management Interventions for Persons with Mental Illness who have been Homeless*. American Journal of Orthopsychiatry, 77(3): 350-361.

Nelson, G., Sylvestre, J., Aubry, T., George, L., & Trainor, J. (2007). *Housing Choice and Control, Housing Quality, and Control over professional support as contributors to the Subjective Quality of Life and Community Adaptation of People with Severe Mental Illness*. Administration and Policy in Mental Health and Mental Health Services Research, 34(2): 89-100.

Nelson, G., Patterson, M., Kirst, M., Macnaughton, E., Isaak, C. A., Nolin, D., & MacLeod, T. (2015). *Life Changes among Homeless Persons with Mental Illness: a Longitudinal Study of Housing First and Usual Treatment*. Psychiatric Services, 66(6): 392-397.

Neptune Network (2015). *Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances*. London, NEPTUNE. Retrieved from: <http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf>

Newcastle City Council (NCC) (2013). *Newcastle's Homelessness Review 2013*. Newcastle, Newcastle City Council. Retrieved from: https://www.newcastle.gov.uk/sites/default/files/wwwfileroot/housing/housing-advice-and-homelessness/2013_homelessness_review_-_2.10.13.pdf

Newcastle City Council (NCC) (2014). *Newcastle City Council Multiple Exclusion Tender*. Newcastle, Newcastle City Council. *Public document available upon request from Newcastle City Council*.

New Economics Foundation (NEF) (2013). *Wellbeing Evidence for Policy: A Review*. Retrieved from: http://b3cdn.net/nefoundation/10b8aabd90c5771ff9_a0m6bvv5a.pdf

- O'Campo, P., Schaefer-McDaniel, N., Firestone, M., Scott, A., & McShane, K. (2009). *Community-based services for Homeless Adults experiencing concurrent Mental Health and Substance Use Disorders: a Realist Approach to Synthesizing Evidence*. *Journal of Urban Health*, 86(6): 965-989.
- Office for National Statistics (ONS) (2016a). *Index of Private Rental Housing Prices, October 2016*. Retrieved from: <https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/indexofprivatehousingrentalpricesreferencetables>.
- Office for National Statistics (ONS) (2016a). *Rough Sleeping Statistics 2011 – 2016 by local authority, October 2016*. Retrieved from: <https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2016>
- Ornelas, J., Martins, P., Zilhão, M.T., & Duarte, T. (2014). *Housing First: an Ecological Approach to Promoting Community Integration*. *European Journal of Homelessness*, 8(1): 29-56.
- Onwuegbuzie, A. J. & Johnson, R.B. (2006). *The Validity Issue in Mixed Research*. *Research in the Schools*, 13(1): 48-63.
- Padgett, D. K., Gulcur, L., & Tsemberis, S. (2006). *Housing First Services for People Who Are Homeless With Co-Occurring Serious Mental Illness and Substance Abuse*. *Research on Social Work Practice*, 16(1): 74-83.
- Padgett, D. K. (2015). *Use of Ethnographic Methods in Research on Homeless Services: Challenges of Integration and Interpretation (Part 1-Clients)*. Society for Social Work and Research 19th Annual Conference: The Social and Behavioral Importance of Increased Longevity, SSWR.
- Padgett, D. K., Smith, B. T., Choy-Brown, M., Tiderington, E., & Mercado, M. (2016). *Trajectories of Recovery Among Formerly Homeless Adults With Serious Mental Illness*. *Psychiatric Services*, 67(6): 610-614.

- Padgett, D.K. (2017) *Qualitative Methods in Social Work Research: Third Edition*. New York. Sage.
- Kindon, S., Pain, R., Kesby, M. (2007) *Participatory Action Research Approaches and Methods: Connecting People, Participation and Place*. London, Routledge.
- Palinkas, L.A., Aarons, G.A., Horwitz, S.M., Chamberlain, P., Hurlburt, M., Landsverk, J. (2011) *Mixed method designs in implementation research*. Administration and Policy in Mental Health and Mental Health Services Research, 38: 44-53.
- Palinkas, L.A., Horwitz, S.M., Green, C.A., Wisdom, J.P., Naihua Duan, Hoagwood, K. (2015) *Purposeful Sampling for qualitative data collection and analysis in mixed method implementation research*. Adm Policy Ment Health, 42(5): 533-544.
- Parsell, C. and Parsell, M. (2012). *Homelessness as a Choice*. Housing, Theory and Society, 29(4): 420-434.
- Parsons, W. (2002). *From Muddling Through to Muddling Up - Evidence Based Policy Making and the Modernisation of British Government*. Public Policy Administration, 17(3): 43-60.
- Patterson, M. L., Rezansoff, S., Currie, L., & Somers, J. M. (2013). *Trajectories of Recovery among Homeless Adults with Mental Illness who Participated in a Randomised Controlled Trial of Housing First: A Longitudinal, Narrative Analysis*. BMJ open, 3(9):e003442
- Patton, M. Q (2002) *Qualitative Research and Evaluation Methods: Third Edition*. Thousand Oaks, CA. Sage Publications.
- Pavot, W. and Diener, E. (2008). *The Satisfaction with Life Scale and the Emerging Construct of Life Satisfaction*. The Journal of Positive Psychology, 3(2): 137-152.
- Pearlin, L. I. and C. Schooler (1978). *The Structure of Coping*. Journal of Health and Social Behavior, 19(1): 2-21.

- Peck, J. (2012). *Austerity Urbanism: American Cities under Extreme Economy*. City 16(6): 626-655.
- Petersen, T. (2009). *Opportunities* in Hedström, P. and Bearman, P. (eds) *The Oxford Handbook of Analytical Sociology*, Oxford, Oxford University Press. 115-139
- Phillips, D. C. (1987). *Philosophy, Science and Social Inquiry: Contemporary Methodological Controversies in Social Science and Related Applied Fields of Research*, Oxford, Pergamon Press.
- Pleace, N. (1998). *Single Homelessness as Social Exclusion: The Unique and the Extreme*. Social Policy and Administration, 32(1): 46-59.
- Pleace, N. (2011). *The Ambiguities, Limits and Risks of Housing First from a European Perspective*. European Journal of Homelessness, 5(2): 113-127
- Pleace, N. (2012). *Housing First*. European Observatory on Homelessness. Brussels, FEANTSA.
- Pleace, N. (2016). *Housing First Guide Europe*. Brussels, FEANTSA.
- Pleace, N., & Bretherton, J. (2013). *The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness*. European Journal of Homelessness, 7(2): 21-41.
- Pleace, N., & Wallace, A. (2011). *Demonstrating the Effectiveness of Housing Support Services for People with Mental Health Problems: A Review*. Research Report, National Housing Federation.
- Pleace, N., Culhane, D., Granfelt, R., & Knutagård, M. (2015). *The Finnish Homelessness Strategy: An International Review*. Helsinki, Ministry of the Environment and the Housing Finance and Development Centre of Finland.
- Plewis, I. (2000). *Educational Inequalities and Education Action Zones* in Pantazis, C. & Gordon, D. *Tackling Inequalities: Where Are We Now and What Can Be Done*, Bristol, Policy Press, 87-100.

- Plumridge, L. & Thomson, R. (2003) Longitudinal qualitative studies and the reflexive self. *International Journal of Social Research Methodology*. 6(3): 213-222.
- Popper, K. (1994) *Models, instruments, and truth: The status of the rationality principle in social sciences*, in Popper, K. & Notturmo, M. A. (eds) *The myth of the framework*, New York, Routledge.
- Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K.D. (2016). *Treatment Access Barriers and Disparities among Individuals with Co-occurring Mental Health and Substance Use Disorders: An Integrative Literature Review*. *Journal of Substance Abuse Treatment*, 61: 47-59.
- Prince, P. N., & Prince, C. R. (2002). *Perceived Stigma and Community Integration among Clients of Assertive Community Treatment*. *Psychiatric Rehabilitation Journal*, 25(4): 323-331.
- Putnam, R. D. (1993) *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton, Princeton University Press.
- Putnam, R. D. (2000). *Bowling Alone: The Collapse and Revival of American Community*, New York, Simon and Schuster.
- Quilgars, D. & Pleace, N. (2016). *Housing First and Social Integration: A Realistic Aim?* *Social Inclusion*, 4(4): 5-15
- Raitakari, S., & Juhila, K. (2015). *Housing First Literature: Different Orientations and Political-Practical Arguments*. *European Journal of Homelessness*, 9(1): 145-189.
- Ravenhill, M. M. (2012). *The Culture of Homelessness*, Farnham, Ashgate Publishing.
- Rhodes, T. (2009). *Risk Environments and Drug Harms: a Social Science for Harm Reduction Approach*. *International Journal of Drug Policy*, 20(3): 193-201.
- Richards, L. (2014). *Handling Qualitative Data: A Practical Guide*, London, Sage.

- Ridgway, P., & Zippel, A. M. (1990). The paradigm shift in residential services: from the linear continuum to supported housing approaches. *Psychosocial Rehabilitation Journal*.
- Roe, G. (2005). *Harm Reduction as Paradigm: Is Better than Bad Good enough? The Origins of Harm Reduction*. *Critical Public Health*, 15(3): 243-250.
- Rolfe, M. (2009). *Conditional Choice* in P. Hedström & P. Bearman (eds), *The Oxford Handbook of Analytical Sociology*, Oxford, Oxford University Press, 419-443.
- Rose, N. S., & Miller, P. P. D. (2008). *Governing the Present: Administering Economic, Social and Personal Life*. Cambridge, Polity Press.
- Rothstein, B. (1998) *Just Institutions Matter: The Moral and Political Logic of the Universal Welfare State*. Cambridge, Cambridge University Press.
- Ryan, G. W. and H. R. Bernard (2003). *Techniques to Identify Themes*. *Field Methods*, 15(1): 85-109.
- Rydgren, J. (2009). *Beliefs* in Hedström, P. & Bearman, P. (eds), *The Oxford Handbook of Analytical Sociology*. Oxford: Oxford University Press, 72 – 93.
- Sahlin, I. (2005). *The Staircase of Transition: Survival through Failure*. *Innovation: The European Journal of Social Science Research*, 18(2): 115-136.
- Saldaña, J. (2003). *Longitudinal Qualitative Research: Analyzing Change through Time*, Lanham, Rowman Altamira.
- Saldaña, J. (2011). *Fundamentals of Qualitative Research*, Oxford, Oxford University Press.
- Salyers, M. P., & Tsemberis, S. (2007). *ACT and Recovery: Integrating Evidence-Based Practice and Recovery Orientation on Assertive Community Treatment Teams*. *Community Mental Health Journal*, 43(6): 619-641.
- Schoon, I., Barnes, M., Brown, V., Parsons, S., Ross, A., & Vignoles, A. (2012). *Intergenerational transmission of worklessness: Evidence from the Millennium Cohort and the Longitudinal Study of Young People in England*. London,

Department for Education. Retrieved from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/183328/DFE-RR234.pdf

Seidman, I. (2013). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. New York, Teachers College Press.

Sen, A. (1993). *Capability and Wellbeing* in D. Hausman (ed.) *The Philosophy of Economics: An Anthology*. Cambridge, Cambridge University Press. 3rd Edition, 30-53.

Sen, A. (1997). *Rationality and Social Choice* in La Manna, M. M. A (ed.) *Readings in Microeconomic Theory*, Dryden Press, London, 439-466.

Sen, A. (1999). *The Possibility of Social Choice*. *American Economic Review*, 89(3): 349-378.

Sen, A. (2000). *Social exclusion: Concept, Application, and Scrutiny*. Social Development Papers No.1, Office of Environment and Social Development.

Shinn, M. & Gillespie, C. (1994). *The Roles of Housing and Poverty in the Origins of Homelessness*. *American Behavioral Scientist*, 37(4): 505-521.

Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., Pascoe, J., & Wood, D. L. (2012). *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*. *Pediatrics*, 129(1): 232-246.

Siegel, D. J. (2001). *Toward an Interpersonal Neurobiology of the Developing Mind: Attachment Relationships, "Mindsight," and Neural Integration*. *Infant Mental Health Journal*, 22(1-2): 67-94.

Siisiainen, M. (2003). *Two Concepts of Social Capital: Bourdieu vs. Putnam*. *International Journal of Contemporary Sociology*, 40(2): 183-204.

Simon, H. A. (1956). *Rational Choice and the Structure of the Environment*. *Psychological Review*, 63(2): 129.

- Simon, H. A. (1990). *Bounded Rationality* in Eatwell, J., Newman, P., & Milgate, M. (eds) *Utility and Probability*, New York, Springer, 15–18.
- Sinha, R. (2001). *How does Stress Increase Risk of Drug Abuse and Relapse?* *Psychopharmacology*, 158(4): 343-359.
- Smith, N. (1992). *Contours of a Spatialized Politics: Homeless Vehicles and the Production of Geographical Scale*. *Social Text*, 33: 55-81.
- Smith, N. (1996). *The New Urban Frontier: Gentrification and the Revanchist City*. London, Routledge.
- Somerville, P. and Bengtsson, B. (2002). *Constructionism, Realism and Housing Theory*. *Housing, Theory and Society*, 19(3-4): 121-136.
- Sorkin, M. (1992). *Variations on a Theme Park: the New American City and the End of Public Space*. New York, Hill and Wang.
- Spurr, H. (2017) *Shut out: The barriers low- income households face in private renting*. London, Shelter. Retrieved from:
http://england.shelter.org.uk/_data/assets/pdf_file/0004/1391701/2017_06_-_Shut_out_the_barriers_low_income_households_face_in_pivate_renting.pdf
- Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). *Housing Choice and Community Success for Individuals with Serious and Persistent Mental Illness*. *Community Mental Health Journal*, 31(2): 139-152.
- Stanhope, V., & Dunn, K. (2011). *The Curious Case of Housing First: The Limits of Evidence Based Policy*. *International Journal of Law and Psychiatry*, 34(4): 275-282.
- Stefancic, A., & Tsemberis, S. (2007). *Housing First for Long-term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention*. *The Journal of Primary Prevention*, 28(3-4): 265-279.
- Stevens, M., Glendinning, C., Jacobs, S., Moran, N., Challis, D., Manthorpe, J., & Netten, A. (2011). *Assessing the Role of Increasing Choice in English Social Care Services*, *Journal of Social Policy*, 40(2): 257-274.

- Tabol, C., Drebing, C., & Rosenheck, R. (2010). *Studies of "Supported" and "Supportive" Housing: A Comprehensive Review of Model Descriptions and Measurement*. *Evaluation and Program Planning*, 33(4): 446-456.
- Tainio, H., & Fredriksson, P. (2009). *The Finnish Homelessness Strategy: From a 'Staircase' Model to a 'Housing First' Approach to Tackling Long-Term Homelessness*. *European Journal of Homelessness*, 3: 181-199.
- Takahashi, L. M. (1996). *A Decade of Understanding Homelessness in the USA: From Characterization to Representation*. *Progress in Human Geography*, 20(3): 291-310.
- Taylor, S., Buchanan, J., & Ayres, T. (2016) *Prohibition, privilege and the drug apartheid: The failure of drug policy reform the address the underlying fallacies of drug prohibition*. *Criminology & Criminal Justice*, 16(4): 452 – 469.
- Teddlie, C., Tashakkori, A. (2003). *Major issues and controversies in the use of mixed methods in the social and behavioral sciences*. In: Tashakkori, A.; Teddlie, C., editors. *Handbook of mixed methods in the social and behavioral sciences*. Thousand Oaks, Sage CA: 3-50.
- Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). *The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS): Development and UK Validation*. *Health and Quality of life Outcomes*, 5(63): 1-13.
- Terry, L. & Cardwell, V. (2015). *Understanding the Whole Person: What are the Common Concepts for Recovery and Desistance Across the Fields of Mental Health, Substance Misuse, and Criminology?*. Revolving Doors Agency. Retrieved from: <http://www.revolving-doors.org.uk/file/1845/download?token=3jprn2sc>
- Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2011). *Social Factors and Recovery from Mental Health Difficulties: a Review of the Evidence*. *British Journal of Social Work*. 42(3): 443-460.

The Mental Health Taskforce to the NHS (2016). *'The five year plan for Mental Health'*. London, NHS.

The King's Fund (2015) *Mental Health Under Pressure*. Retrieved from: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/mental-health-under-pressure-nov15_0.pdf

Thomson, R., Bell, R., Henderson, S., McGrellis, S., & Sharpe, S. (2002). *Critical Moments: Choice, Chance and Opportunity in Young People's Narratives of Transition*. *Sociology*, 36(2): 335-354.

Thomson, R. (2007). *The Qualitative Longitudinal Case History: Practical, Methodological and Ethical Reflections*. *Social Policy and Society*, 6(4): 571-582.

Thomson, R. and Holland, J. (2003). *Hindsight, Foresight and Insight: The Challenges of Longitudinal Qualitative Research*. *International Journal of Social Research Methodology*, 6(3): 233-244.

Tiderington, E. L. (2015). *Ethnographic Methods in Research on Homeless Services: Challenges of Integration and Interpretation (Part 2-Case Managers)*. Society for Social Work and Research 19th Annual Conference: The Social and Behavioral Importance of Increased Longevity, SSWR.

Tinland, A., Fortanier, C., Girard, V., Laval, C., Videau, B., Rhenter, P., Greacen, T., Falissard, B., Apostolidis, T., & Lancon, C. (2013). *Evaluation of the Housing First Program in Patients with Severe Mental Disorders in France: Study Protocol for a Randomized Controlled Trial*. *Trials*, 14(1): 309.

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I., & Davidson, L. (2006). *Others: The Role of Family, Friends, and Professionals in the Recovery Process*. *Archives of Andrology*, 9(1): 17-37.

Torrance, H. (2012). Triangulation, respondent validation, and democratic participation in mixed methods research. *Journal of Mixed Methods Research*. 6(2): 111 – 123.

- Toro, P. A. (2007). *Toward an International Understanding of Homelessness*. Journal of Social Issues, 63(3): 461-481.
- Treanor, M. (2015). *The Effects of Financial Vulnerability and Mothers' Emotional Distress on Child Social, Emotional and Behavioural Wellbeing: A Structural Equation Model*. Sociology, 50(4): 673-694.
- Tsemberis, S. (2010). *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction Manual*. Philadelphia, Hazelden.
- Tsemberis, S. (2013). *Housing First and Systems Change for Housing & Mental Health Services*. International Housing First Conference. Retrieved from: <http://hf.aeips.pt/wp-content/uploads/2013/10/Tsemberis.pdf>
- Tsemberis, S. (2014). *Evidence-based Values in Housing and Treatment*. Psychiatric Services, 65(3): 277-277.
- Tsemberis, S., & Eisenberg, R. F. (2001). *Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities*. Primary Care Companion to the Journal of Clinical Psychiatry, 3(1): 34-35.
- Tsemberis, S., Gulcur, L., & Nakae, M. (2004). *Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis*. American Journal of Public Health, 94(4): 651-656.
- Turner, T. (2004). The history of Deinstitutionalization and Reinstitutionalization. Psychiatry, 3(9): 1-4.
- Turner, J. H. & Stets, E. (2005). *The Sociology of Emotions*, Cambridge, Cambridge University Press.
- Valentine, G. (2005). *Geography and ethics: moral geographies? Ethical commitment in research and teaching*. Progress in Human Geography, 29(4): 483-487
- Van der Kolk, B. A. (2015). ***The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma***. New York, Penguin.

- Van Oorschot, W., & Finsveen, E. (2009). The welfare state and social capital inequality: An empirical exploration using longitudinal European/World Values Study data from 13 Western welfare states. *European societies*, 11(2), 189-210.
- Van Roeyen, S., Anderson, S., Vanderplasschen, W., Colman, C., & Vander Laenen, F. (2016). *Desistance in Drug-Using Offenders: A Narrative Review*. *European Journal of Criminology*: 1-20.
- Volk, J. S., Aubry, T., Goering, P., Adair, C. E., Distasio, J., Jette, J., & Tsemberis, S. (2015). Tenants with Additional Needs: when Housing First does not solve Homelessness. *Journal of Mental Health*: 25(2): 169-175.
- Waegemakers Schiff, J., & Rook, J. (2012). *Housing First-Where is the Evidence?* Canadian Homelessness Research Network. Retrieved from: http://www.homelesshub.ca/sites/default/files/HousingFirstReport_final.pdf
- Walker, K., Brown, S., & Bowen, E. (2013). *Psychological and Criminological Factors associated with Desistance from Violence: A Review of the Literature*. *Aggression and Violent Behavior*, 18(2): 286-299.
- Weaver, B. (2015). *Offending and desistance:The Importance of Social Relations*, London, Routledge.
- Weaver, B. & McNeill, F. (2015). *Lifelines Desistance, Social Relations, and Reciprocity*. *Criminal Justice and Behavior*, 42(1): 95-107.
- Weber, M. (1949). *Objectivity in Social Science and Social Policy*. *The Methodology of the Social Sciences*, 78: 50-112.
- Webster, C., Macdonald, R., & Simpson, M. (2006). "Predicting criminality? Risk factors, neighbourhood influence and desistance." *Youth Justice* 6(1): 7-22.
- Webster, D., 2014. 'JSA Sanctions and Disallowances', *Evidence submitted to the House of Commons Work and Pensions Committee Inquiry into the Role of Jobcentre Plus in the Reformed Welfare System*, Second Report of Session 2013 - 14 (2): 90-101.

- Wengraf, T. (2001) *Qualitative Research Interviewing*. London, Sage.
- White, W. L. (2007). *Addiction Recovery: Its Definition and Conceptual Boundaries*. *Journal of Substance Abuse Treatment*, 33(3): 229-241.
- White, W. L., & Kelly, J. F. (2010). *Recovery Management: What if we Really Believed that Addiction was a Chronic Disorder?* In Kelly, J. F. *Addiction Recovery Management: Theory, Research, and Practice*, New York, Springer. 67–84.
- Whiteford, M. (2010). *Hot Tea, Dry Toast and the Responsibilisation of Homeless People*. *Social Policy and Society*, 9(2): 193-205.
- Wikström, P.-O. H. (2004). *Crime as Alternative: Towards a Cross-Level Situational Action Theory of Crime Causation* in McCord, J. (ed.) *Beyond Empiricism: Institutions and Intentions in the Study of Crime*, New Brunswick, Transaction, 1-37.
- Wikström, P.-O. H. (2005). *The Social Origins of Pathways in Crime: Towards a Developmental Ecological Action Theory of Crime Involvement and its Changes*. In Farrington, D. (ed.) *Integrated developmental and Life-Course Theories of Offending*, New Jersey, Transaction, 211-245.
- Wikström, P.-O. H., & Treiber, K. (2007). *The Role of Self-Control in Crime Causation Beyond Gottfredson and Hirschi's General Theory of Crime*. *European Journal of Criminology*, 4(2): 237-264.
- Wikström, P. O. H. (2014). *Why Crime happens: A Situational Action Theory* in Manzo, G. (ed.) *Analytical Sociology: Actions and Networks*, London, Wiley-Blackwell, 71-94.
- Willse, C. (2010). *Neo-liberal Biopolitics and the Invention of Chronic Homelessness*. *Economy and Society*, 39(2): 155-184.
- Wolch, J. R., Dear, M., & Akita, A. (1988). *Explaining Homelessness*. *Journal of the American Planning Association*, 54(4): 443-453.
- Wong, Y.-L. I., Park, J. M., & Nemon, H. (2006). *Homeless Service Delivery in the Context of Continuum of Care*. *Administration in Social Work*, 30(1): 67-94.

- Woodhall-Melnik, J. R., & Dunn, J. R. (2015). *A Systematic Review of Outcomes Associated with Participation in Housing First Programs*. *Housing Studies*, 31(3): 1-18.
- Wright, S., (2012). *Welfare-to-work, Agency and Personal Responsibility*. *Journal of Social Policy*, 41(2): 309-328.
- Yanos, P. T., Barrow, S. M., & Tsemberis, S. (2004). *Community Integration in the Early Phase of Housing among Homeless Persons Diagnosed with Severe Mental Illness: Successes and Challenges*. *Community Mental Health Journal*, 40(2): 133-150.
- Young, Y. (2014). *Social Context and Social Capital: Governance, Inequality, and the Individual Experience*. *International Journal of Sociology*, 44(2): 37-62.

Appendix B

B.1: Examples of Domains and Composite Measures for Outcome Measurement in Housing First and Life History Categorisation

B.2: Personal Capacity for Choice and Control: Analysis and Discussion of Participant 'Needs' and 'Capabilities'

B.3: Situational Vignettes of Participant Turning Points

B.1.1: Example of Domains and Composite Measures for Outcome Measurement in Housing First

Table B.1: Domains and Composite Measures for Outcome Measurement in Housing First (Arnie)

Outcome Domain	Sub Domains	Composite Measures	Measure Categorisations	Data Type	Source	Stage 1 - June - August 2015(0 - 3 Mths) - <i>Compare with retrospective account of homeless situation</i>	Stage 2 - January - April 2016 (7- 10 Mths) - <i>compare with stage 1</i>	Stage 3 - July - September 2016 (13 - 16 Mths) - <i>compare with stage 1 and 2</i>	Outcome Trajectory	Domain Trajectory
Housing	Housing Allocation	Waiting Time from service pick up	< 4 weeks, 4 - 6 weeks, 6 - 8 weeks, 8 - 12 weeks, 12+ weeks	Quantitative	Gateway data	8 - 12 weeks				
		Choice' enabled over location?	Yes/No	Qualitative	Interviews	Yes (area)				
		Property viewed by participant prior to tenancy start?	Yes/No	Qualitative	Interviews	Yes				
	Housing Retention	Time Retained (months)	3, 6, 9, 12, 18, 24+	Quantitative	Gateway data	0	5	13		

Housing (cont.)	Housing Retention (cont.)	Paying rent Top up?	no top up, yes, no	Qualitative	Interviews	no top up				
		Paying utility bills?	yes, no	Qualitative	Interviews	not in property	no	no		
		Paying council tax?	yes, no	Qualitative	Interviews	not in property	no	no		
	Ontological Security	Housing Quality (subjective report)	Positive, Neutral, Negative	Qualitative	Interviews	not in property	positive	negative		
		Neighbourhood satisfaction (subjective report)	Positive, Neutral, Negative	Qualitative	Interviews	positive - choose property for area	negative - peers coming in	neutral		
		Attempt at 'home making' (evidence in purchases, use of all rooms, researcher reported cleanliness)	Sustained Attempt, Fluctuating Attempt, No or little Attempt	Qualitative	Interviews, updates, photos	not in property	no or little attempt	no or little attempt		

Mental Health	MH support and treatment	Receiving Treatment?	Yes/No	Qualitative	Interviews, updates	No	No	No		
		Satisfied with treatment?	Yes/No	Qualitative	Interviews, updates	N/A	N/A	N/A		
	Change	Subjective Report	Improvement, Static, Decline	Qualitative	Interviews, updates	Improvement	Static	Static		
Physical Health	Subjective Report	Single Item	Psychometric Score	Quantitative	Interviews	5	5	5		
		Difference Described?	Improvement, Static, Decline	Qualitative	Interviews, updates	Improvement (just had detox)	Decline (in hospital, weight loss and regular fits)	Static		
Wellbeing	Mental Wellbeing	SWEMWBS	Psychometric Score	Quantitative	Interviews	30	33	29		
	Hedonic Wellbeing	SWLS	Psychometric Score	Quantitative	Interviews	4	1	3		
	Quality of Life	QoL single item	Psychometric Score	Quantitative	Interviews	4	1	5		

Substance Misuse	SM Support and Treatment	Receiving Treatment?	Yes/No	Qualitative	Interviews, updates	Yes (hospital detox)	No	Yes (but familiar offer)		
		Satisfied with treatment?	Yes/No	Qualitative	Interviews, updates	Yes	N/A	No		
	Change	Level of Usage	Increase, static, reduction, cessation	Qualitative	Interviews, updates	Reduction	Increase (to pre detox level)	Static		
		Sense of Control over usage	Reduced, Increased, Static	Qualitative	Interviews, updates	Increased	Reduced	Static		
		Harms Associated to Usage	Reduced, Increased, Static	Qualitative	Interviews, updates	Reduced	Increased	Static		

Offending & Street Culture	Offending	Offending History	Overview of offending history	Qualitative	Updates	Extensive offending history around theft and deception. Largely associated to alcohol usage			
		Criminal Charges	Number and type at each stage	Qualitative	Interviews, updates	2 - 3 charges for D&D/ PSPO breach	None	None	
		Criminal Convictions	Number and type at each stage	Qualitative	Interviews, updates	Fines offered	None	None	
		Non Criminal Violent Behaviour	No incidents, two or less incidents, recurring incidents (2+)	Qualitative	Interviews, updates	No incidents noted	No incidents noted	No incidents noted	
	Street Culture	Begging'	None, irregular, regular	Qualitative	Interviews, updates	regular	regular	regular	
		Street Drinking	None, irregular, regular	Qualitative	Interviews, updates	regular	regular	regular	
		Rough Sleeping	None, irregular, regular	Qualitative	Interviews, updates	regular	regular	regular	

Meaningful Activities	Employment & Volunteering	Employment	Formal, Informal, voluntary, None	Qualitative	Interviews, updates	none	none	none		
		Formal	started, considering, not considering	Qualitative	Interviews, updates	not considering	not considering	not considering		
		Informal	started, considering, not considering	Qualitative	Interviews, updates	not considering	not considering	not considering		
		Mandatory	Mandated or not mandated	Qualitative	Interviews, updates	not mandated	not mandated	not mandated		
	Education & Training									
Social Connections		Presence of 'Friends'	Presence of 'friends' with subjectively positive influence	Qualitative	Interviews, updates	none	none	none		
		Presence of 'Associates'	Presence of 'associates' with subjectively negative influence	Qualitative	Interviews, updates	yes, many	yes, many	yes, many		
	Family	Presence of Family	strong presence, some but	Qualitative	Interviews, updates	some but limited	some but limited	some but limited		

Social Connections (cont.)	Family (cont.)	Presence of family (cont.)	limited presence, no presence			presence (in laws)	presence (in laws)	presence (in laws)		
		Influence of family	Positive family influence, neutral or mixed family influence, negative family influence	Qualitative	Interviews, updates	neutral/ negative family influence	neutral/ negative family influence	neutral/ negative family influence		
	Support Worker	Relationship	Subjectively positive, neutral or negative	Qualitative	Interviews, updates	positive	positive	positive		
		Frequency	<once a week, once a week, 2+ x a week	Quantitative	Interviews	2+ x a week	2+ x a week	2+ x a week		
	General Social Trust	Social trust single item measure	Psychometric Score	Qualitative	Interviews, updates					
						6	4	0		

Finance & Debt	Finance	Rent & Top up	top up being paid?	Qualitative	Interviews, updates	not in property	no top up	no top up		
		Bill Payments	all bills paid, most bills paid, few bills paid, no bills paid	Qualitative	Interviews, updates	not in property	no bills paid	no bills paid		
Finance & Debt (cont.)	Debt	Old Debt	Old Debt re-emerged?	Qualitative	Interviews, updates	no debt re-emerged	no debt re-emerged	no debt re-emerged		
		New Debt	New Debt Present?	Qualitative	Interviews, updates	new debt	new debt	new debt		
	Welfare	Conditionality	Conditions Present?	Qualitative	Interviews, updates	None	None	None		
Personal Priorities		Sanctions	Sanctions experienced ?			None	None	None		
	Additional weighting given to measures associated to PPO's									

B.1.2: Example of Domains and Composite Measures used in Life History Categorisation

Table B.2: Domains and Composite Measures used in Life History Categorisation (Lyla)

Domain	Sub Domains	Composite Measures	Measure Categorisations	Data Type	Source	Finding
Demographics	Age	Age	18 - 25, 26 - 35, 35 - 50, 50 - 60, 60+	Quantitative	Gateway	35 - 50 (37)
	Gender	Gender	Male/Female	Quantitative	Gateway	Female
	Nationality	Nationality		Quantitative	Gateway	English
Housing	Previous Housing Experience	Previous tenancies	None, number of years in tenancies	Mixed	Interviews, Gateway	one (<1 year)
		Evictions	Number of Evictions	Mixed	Interviews, Gateway	none
		Tenancy Management	Paid Bills, rent etc. self? (yes/no)	Qualitative	Interviews	yes
	Homeless Situation	Number of Placements	None, <2, 2 - 5, 5 - 8, 8+	Quantitative	Gateway	11
		Number of Evictions	None, <2, 2 - 5, 5 - 8, 8+	Quantitative	Gateway	11
		Time spent in Homeless Situation	<1 year, 1 - 3 years, 3 - 5 years, 5 - 10 years, 10+ years	Mixed	Interviews, Gateway	20 years

Childhood	Family	Subjective Opinion of Family	positive, neutral, mixed, negative	Qualitative	Interviews	negative
		Subjective Opinion of Parents	positive, neutral, mixed, negative	Qualitative	Interviews	negative
	Childhood Environment	Subjective Report of Childhood	positive, neutral, mixed, negative	Qualitative	Interviews	negative
	Presence of Risk Behaviours	Violence	present, not present, data missing	Qualitative	Interviews	present
		Offending	present, not present, data missing	Qualitative	Interviews	present
		Mental health Issues	present, not present, data missing	Qualitative	Interviews	present
		Substance Use	present, not present, data missing	Qualitative	Interviews	present
Mental Health	Trauma	Childhood Trauma Reported?	Yes/No	Qualitative	Interviews	yes
		Childhood Neglect Reported?	Yes/No	Qualitative	Interviews	yes
		Adolescent Trauma Reported?	Yes/No	Qualitative	Interviews	yes
		Adult Trauma Reported?	Yes/No	Qualitative	Interviews	yes
		Severity of Trauma	High, medium, low	Qualitative	Interviews	high
	Diagnosis	Presence of Diagnosed Psychiatric Disorder	Name of Disorder	Mixed	Interviews	schizophrenia, bipolar, PD, depression
		Time Diagnosed	Number of years since diagnosis	Qualitative	Interviews	

Physical Health	Chronic Disorders	Presence of Chronic Disorders	Names of Disorders	Qualitative	Interviews	none
	Other Health Issues		Names of other health issues	Qualitative	Interviews	stomach issues
Substance Misuse	History of Substance Misuse	Origins of SM	Period in life where SM issues started?	Qualitative	Interviews	adolescence (14)
	Dependencies	Types of Drugs around with dependencies have formed	Note drug types	Qualitative	Interviews	heroin, amphetamines, alcohol, cocaine, perscription, valium, NPS
		Dependencies persisting	Note key dependencies which still persist	Qualitative	Interviews	valium, alcohol, methadone
	Abstinence/Treatment	Periods of Abstinence	Reported (number of length), none reported	Qualitative	Interviews	heroin (6 years)
		Periods of Treatment	Reported (number), none reported	Qualitative	Interviews	methadone, repeated detox
		Cessation	any drugs which cessation has been acheived	Qualitative	Interviews	heroin, NPS, cocaine

Offending & Street Culture	History of Offending	Type of Offending	Types of Offending reported	Qualitative	Interviews	violence, theft
		Imprisonment	Number of years in prison	Qualitative	Interviews	1 year
			Number of years since last prison sentence (at start of study)	Qualitative	Interviews	4 years
	History of Street Culture	History of Begging	Yes/No	Qualitative	Interviews	yes
		History of Street Drinking	Yes/No	Qualitative	Interviews	yes
		History of Rough Sleeping	Yes/No	Qualitative	Interviews	yes
Meaningful Activities	Employment	Any Employment Noted?	Yes/No	Qualitative	Interviews	no
		Number of Years employed?	Number of years	Qualitative	Interviews	n/a
	Education	Finished Secondary School?	Yes/No	Qualitative	Interviews	no
		Engagement	Good, poor	Qualitative	Interviews	poor
		Exclusions?	Yes (number), No	Qualitative	Interviews	yes

Social Connections (Adulthood)	Romantic Relationships	Romantic Relationships noted	Yes(number)/No	Qualitative	Interviews	yes (3)
		Domestic Violence?	Yes/No	Qualitative	Interviews	yes
		Relationship Breakdown	Yes(number)/No	Qualitative	Interviews	yes (3)
		Married (incl. common law)	Yes (number), No	Qualitative	Interviews	no
	Children	Had Children?	Yes (number), No	Qualitative	Interviews	yes (3)
		Legal access to Children?	Yes/ No	Qualitative	Interviews	no
		Contact with Children?	Yes/No	Qualitative	Interviews	no
Finance & Debt	Financial Security	Previously financially secure?	Yes/No	Qualitative	Interviews	no
		Issues with Debt	Yes/No	Qualitative	Interviews	yes

B.2: Personal Capacity for Choice and Control: Analysis and Discussion of Participant ‘Needs’ and ‘Capabilities’

Exploring adverse experiences and needs in the personal histories of MEH individuals is common. Section B.2.1 outlines the findings of the needs based analysis focused primarily on those broad needs categories associated to MEH adults (substance misuse, mental health, offending, street culture and homelessness).

Section B.2.2 discusses findings relating to participants’ experience of relevant capabilities; such as tenancy sustainment, educational attainment and employment experience.

B.2.1: The Extent and Severity of ‘Needs’ in Participant’s Life Histories

Fitzpatrick et al., (2011) identified a high degree of overlap between experiences of homelessness, substance misuse, institutional care and ‘street culture’ activities. In a subsequent publication, they highlighted five experiential clusters within the MEH population based on the extent and complexity of the needs faced by these individuals, including the same criteria, with the addition of adverse life events (Fitzpatrick et al., 2012). In doing so, the authors identified experiences of childhood trauma related most closely to those with the most complex needs. The temporal sequencing of these needs was highly consistent throughout the life histories of these individuals, with substance misuse and mental health issues preceding homelessness and a range of adverse life events.

This study was on a much smaller scale and explored participant’s life histories using primarily qualitative methods. Nevertheless, the aim of exploring the incidence and complexity of adverse experiences, broadly termed ‘needs’, remained the same. Following Fitzpatrick et al. those needs deemed most relevant were

traumatic/ adverse life experiences, homelessness, substance misuse, mental health issues, offending and 'street culture activities'. The particular definitions applied to each of these are discussed in subsequent sections, alongside discussion of their distribution across participants' life histories. Throughout, the impact of these needs on participants' capacity for making informed and deliberative intertemporal choices, in line with recovery and desistance orientated outcomes, are considered.

Substance Misuse and Addiction

Although substance misuse issues were common in the lives of all participants, the severity of these issues varied considerably. The severity of substance misuse needs differed in two key ways:

- The type of drug used in terms of its purpose (e.g. painkiller)
- The number of drugs used concurrently (i.e. either a single substance misuse issue or poly misuse)

First, it worth making comment on when and why substance misuse originated in the lives of participants.

Substance Misuse Origins

The majority of participants (n=7) reported that their substance use issues originated in early adolescence and developed in young adulthood. A further five participants (Bev, Gary, James, Johnny, Lisa) reported that their issues with alcohol or drugs developed during late teens. However, it is important to note that Bev and Johnny's current substance misuse issues (at the start of the study) developed in their 20's and 30's respectively. Only two participants described their issues as developing in middle age (Jimmy, Joseph). Both had engaged in alcohol use prior to these periods, but did not consider it as an issue until this age.

When asked about the reasons why their substance use became an issue, the majority of participants (n=10) attributed it to either a singular or series of adverse or traumatic events. For eight of these participants, these events were either related to the loss of someone close to them through death (Linda, Jimmy, Carl, Liam), romantic relationship breakdown (Johnny) or neglect and abuse in various forms during childhood (Gary, Lenny, Lyla)⁶¹:

“As soon as I was old enough to buy a bottle of cider, I’d go and buy a bottle of cider. And that was just to kill the pain of the way I was living, like me home life.”

(Lenny. Static Trajectory)

Lisa attributed her substance misuse issues to:

“Just getting in with the wrong people and that, just having a bit of a sh**ty life and that, then I just hit the drugs.”

(Lisa. Positive Trajectory)

Lisa’s quote demonstrates a wider trend across the experiences of all participants. That ‘local social networks’ were prominent influences over many participants’ decisions to engage in substance misuse. Using Wikstrom’s (2004) understanding of temptation as constitutive of desire and opportunity can help us understand the influence of not only adverse events in individuals’ lives, but also the environment in which they were coping with these adverse events. For at least ten, the *desire* to engage in substance use emerged from adverse life events of varying severity. However, the *opportunity* most commonly came through social networks who engaged in substance abuse too. These social networks took varying forms, for Liam they were colleagues in the Army, for Joseph it was his brother, but for most those networks were made up of friends and associates.

⁶¹ The relationship between trauma, adverse life experiences and substance misuse is explained in section 3.5.2

“No I didn’t have to use them, but the certain place I’ve been brought up and the people around is, they were available and things like, you know, and that’s what I knew.”

(Johnny. Positive Trajectory)

Self-reported Substance Dependencies and Issues

Similarly to Fitzpatrick et al. (2011, 2012) the most common substance misuse issue amongst participants was alcohol (n=11), with nine participants forming a dependency. The second most common was heroin (n=7), all participants who used heroin formed some sort of dependency, albeit over varying periods of time. For example, Johnny’s heroin use only lasted two years before he transitioned to methadone, reporting no further heroin usage after this point. On the other hand, Lyla’s heroin problem extended over at least a decade. Other common substances around which dependencies or issues formed were amphetamines (n=6), diazepam (Valium) (n=4), synthetic cannabinoids (n=4), cocaine (n=4) and marijuana (n=2).

Table B.1 shows the variability in drug type and in poly use across participants. An ‘X’ indicates that the participants described having a substance misuse issue and/or dependency at some point in their life.

<i>Table B.3: Substance Type and Number of Substances around which issues have subjectively developed</i>							
	Alcohol	Cocaine	Amphet- amines	Heroin	Synthetic Cannabinoid	Valium	Marijuana
Arnie	X	X					
Bev	X		X				
Carl	X		X	X	X	X	
Gary	X						X
James				X	X	X	
Jimmy	X						

Table B.3 continued

Joel		X	X	X		X	
Johnny	X		X	X			
Joseph	X						
Liam	X						
Lenny	X	X	X	X			
Lisa				X	X		
Linda	X						X
Lyla	X	X	X	X	X	X	

As displayed in table B.3, there was considerable variation in the number of substances that participants developed issues around during their lives. Some only experienced singular issues around alcohol (Jimmy, Joseph, Liam) with others developing issues around alcohol and one other substance (Arnie, Bev, Gary, Linda, Johnny). However, a considerable number of participants developed poly substance misuse issues to varying degrees (Carl, James, Joel, Lenny, Lyla). Johnny is not included here as his substance issues occurred in isolation, each occurring singularly at different points in the life course.

Among the most severe experiences of poly substance use were those described by Joel and Lyla:

“I was a raging smack head, I was a raging coke head, I was a raging alcoholic, and I was on 120ml of, this is prescribed this I’m gonna tell ya. 120ml of meth a day, 40ml of valium a day, 37.5 zopiclone [insomnia] and 45ml of mirtazapine [atypical antidepressant] a day, prescribed. And I was on 5 packets of heroin a day, 3 packets of coke a day and 3 bottles of tudor rose a day.”

(Lyla. Fluctuating Trajectory)

“I was injecting everything, amphetamine, cocaine, heroin, I was even injecting methadone but I lost all the arteries in me legs, you know, well, I

died a few times. You know I had like six operations on me groins and me stomach and me legs, nearly lost me legs.”

(Joel. Fluctuating Trajectory)

In wave one of this study, there was a similar separation between those participants experiencing singular and poly substance use issues, as displayed in table B.4.

Table B.4: Substance Use Issues described at Wave One							
	Alcohol	Cocaine	Amphet- amines	Heroin	Metha- done	Synthetic Cannabinoid	Valium Marijuana
Arnie	X						
Bev	X						
Carl				X	X	X	X
Gary							
James				X		X	X
Jimmy	X						
Joel							X
Johnny					X		
Joseph	X						
Liam	X						
Lenny	X			X		X	
Lisa					X		
Linda	X						
Lyla	X			X	X	X	X

Ten participants were experiencing singular substance use issues. Among these participants, Johnny and Lisa were primarily using methadone, but both wished to reduce. Linda had an alcohol issue but unlike most other participants this was ‘binge’ related rather than representing an ongoing dependency. The remaining four participants were experiencing poly substance issues (Carl, James, Lenny, Lyla). Among these four participants, the use of strong emotional ‘painkiller’ type

drugs was particularly common; opioids (heroin and methadone), benzodiazepine (Valium) and synthetic cannabinoids which are designed to mimick marijuana but commonly have much higher potency and are similar in effect to some opioids (Baumeister, Tojo et al. 2015; Neptune, 2015). Importantly, each of these participants also expressed experiences of childhood abuse and neglect. As outlined in section 3.5.2, the link between such experiences in childhood and the onset of substance abuse is identified in the seminal ACE survey (Felitti et al. 1998). More recently, others have identified that these ‘painkiller’ drugs are particularly related to traumatic experiences, emphasising that early experience of these issues has a more profound impact on an individual’s cognitive development and desire for the emotional relief offered by opioids in particular (Kim & Ford, 2010; Maté, 2012). Joel was the only other participant who reported severe physical and sexual abuse in adolescence, and although he only reported using marijuana at the start of the study, he had been a poly drug user until relatively recently (see table B.4) and relies on prescription medication alongside his marijuana use.

Overall, there was considerable variability in the severity of participants’ substance use issues, both through their lives and at wave one in this study. It is worth highlighting here that in a similar way that traumatic and adverse experiences can encourage the choice to engage in substance use, substance use can also affect the choices of an individual.

Firstly, intoxication impairs the capacity for self-control, essential for making the deliberative choices to enable longer term outcomes (section 3.5.2). We may consider this as another personal factor that contributed to consistent experiences of being ‘trapped’ in cycles of substance use within a homeless setting (see section 6.2.4). In turn, when a dependency forms around a substance an individual’s ‘choice’ over whether to take a substance or not is restricted. This is a key basis of the harm reduction approach applied in HF (Tsemberis et al., 2004; Roe, 2005).

As noted, for some participants the purpose of substance use was as an emotional painkiller or as a means of self-medication. Without other capabilities on which to draw when dealing with emotional stressors, the participant is left with limited action alternatives, leading to an automatic choice of substance use, as in their experience this brings short term relief (see figure 3.1). The priorities of most participants either explicitly or implicitly involved the reduction or cessation of substance use (section 5.2.1). In turn, their capacity to gain control over their lives and direct it towards favourable outcomes is arguably more restricted than those participants whose substance misuse issues are less severe and are not underpinned by complex trauma.

Mental Health Issues and Traumatic Experiences

The severity of participants mental health needs varied considerably, mainly according to:

- The type of mental health issue
- The number of coexisting mental health issues

Table B.3 displays those mental health issues which participants self-reported as having been diagnosed with by a mental health professional. Of course, there is the possibility that participants' self-reports were inaccurate either in their diagnosis or in the individual who diagnosed them. Pleave (2016) highlights this as a potential issue for many HF evaluations, and as such, these findings should be treated with some caution. Nevertheless, these issues are largely representative of the mental health issues faced by this group (Fitzpatrick et al., 2011) and were validated by case managers, therefore they merit further discussion.

Table B.5: Self-Reported Mental Health Issues for which participants had been diagnosed							
	Depression	Bi Polar	Paranoid Schizo-phrenia	Anger Management Issues	Post-Traumatic Stress Disorder (PTSD)	Anti-Social Personality Disorder (ASPD)	Eating Disorder
Arnie	X						
Bev							X
Carl	X	X					
Gary	X			X			
James	X			X			
Jimmy	X						
Joel			X				
Johnny							
Joseph	X						
Liam					X		
Lenny	X						
Lisa	X						
Linda	X			X			
Lyla	X	X	X			X	

In line with findings from Fitzpatrick et al. (2011, 2015), by far the most common mental health issue experienced by participants was depression (n=11). For many participants this was the only mental health issue they reported. However, some participants did have other emotional mental health issues such as profound

anger management issues⁶² (Gary, James, Linda), and bi polar disorders (Lyla, Carl). Both Lyla and Joel had also been diagnosed with paranoid schizophrenia. Bev had been diagnosed with an eating disorder in her late teens and early 20's but was in stable recovery in relation to this particular issue. Liam was the only participant who noted an official diagnosis of PTSD, although experiences of trauma were consistent throughout participants' life histories.

Although many participants may be conceived as 'self-harming' through substance use, only Joel noted ongoing experiences of self-harm.

"I can't say that I'm gonna stop self-harming cos obviously I'm a prolific self-harmer, I done it for 24 year."

(Joel. Fluctuating Trajectory)

Only Bev could be considered in stable mental health recovery. For the majority of participants these were issues which continued to affect them as they entered their HF tenancy. It is relevant at this point to consider the ways in which these mental health issues may impede participants' capacity to make deliberative, intertemporal choices towards subjectively desirable long term outcomes.

Firstly, more severe diagnoses such as paranoid schizophrenia can directly influence participants' perception of events meaning they may be less able to make 'informed' deliberative decisions⁶³. Depression inherently inhibits an individual's capacity for motivation. In turn, a lack of motivation may lead to participant's deferring important choices about their recovery (Keat et al., 1994).

The ongoing anger management issues reported by three participants increase the likelihood that when faced with provocation, these participants will select an affective, automatic choice process in which they favour immediate response over a deliberative, restrained and 'civilised' response favoured by wider

⁶² Classified as profound as these individuals were offered mental health support or medication.

⁶³ Sections 3.4 and 3.5 discuss the importance of perception in determining how an event, object or person is internally represented and therefore employed in future decisions.

social norms and replicated in legal norms⁶⁴ (Freese, 2009). The following quotes demonstrate how these affective responses impacted participants in their property, as well as their capacity to reach long term outcomes such as employment:

“Aye I’ve had, I nearly had a fight with him upstairs.. cos they’ve been hoying sanitary towels down the toilet.. and he(neighbour) started shouting at is, and he spat in me face, and I was raging there, and when he went to go out the door there I threw a knife at him, because before I was on me medication I was just, I was flipping.. “

(James. Fluctuating Trajectory)

“Just generally I’ve got quite a bad temper in high pressure situations. So like any jobs that are quite fast paced, which most jobs are ... In those situations I’m not equipped with being shouted at or dictated to in such a way that is antagonising. So if I feel that it is antagonising even if it’s a manager or what not, that won’t bother me, I’ll just fly off the handle and that means I lose my job.”

(Gary. Fluctuating Trajectory)

For Gary and James, limitations in their ability to manage their emotions induced a desire to engage in an action in conflict with known moral and social norms. However, both seemed to be aware that the action was wrong, contradicting Elster’s (1996) proposition that negative emotions can bias cognition to obscure the wrongness of that action.

Traumatic Experiences

Another key area of difference was the severity of the traumatic experiences participants faced. To some extent these have been discussed in earlier sections, however it is worth making further comment on the variance in participants’ experience of trauma. Lyla experienced persistent sexual abuse and Lenny experienced persistent physical abuse.

⁶⁴ See section 3.5.2 for discussion of behavioural preferences and how these preferences can conflict with wider social norms.

“You know, I’ve been abused, me mam used to put me in bed with the person who abused me. She used to go downstairs and as she was drinking she used to know that I was getting raped upstairs”

(Lyla. Fluctuating Trajectory)

“Aye, well we never had a home, you know what I mean, never had no lowy, never had no food in the cupboards so, everything went on the drink, mother and stepfather ... Me and me stepfather didn’t use to get on, he used to beat is all the time”

(Lenny. Static Trajectory)

Gary described emotional abuse from his adoptive parents who agreed for him to be put on high doses of Ritalin after a diagnosis of ADHD. Gary’s experience supports Van der Kolk’s (2016) contention that too often childhood behavioural issues are treated with medication, which can have further harmful effects on the ability of these individuals to engage in productive and meaningful lives. In Gary’s case, this was the development of substance use issues and the internalisation of social labels applied to him.

“Why they caused those addictions, why they made me out to be a bad person, you know categorising me to be this sort of person. If you’re gonna categorise someone to be that person then they could turn out to be that person.”

(Gary. Fluctuating Trajectory)

Although, other participants didn’t directly attribute their substance misuse issues to neglect and abuse in childhood, three did describe histories of neglect (Joel, James, Arnie), with two also facing physical abuse in juvenile detention centres (Arnie, Joel). Throughout participants’ accounts it was clear that those with more stressful childhoods and with greater incidence of traumatic experiences had

more severe mental health and substance use issues (Felliti et al., 1998; Shonkoff et al., 2012; Maté, 2010).

Offending Behaviours and Street Culture

In contrast to the other needs domains outlined so far, offending and ‘street culture’ activities can be thought of both as needs and capabilities, albeit capabilities which conflict with legal norms. As Lyla notes begging can be conceived as a form of work:

“Worked me whole life darling, and d’you know I’ve had to sit on the streets of Newcastle and beg.. I have, I’ve had no choice but to do it darling.”

(Lyla. Fluctuating Trajectory)

For this reason, the types of crimes in which participants engaged are commonly termed ‘survival crimes’ (Bowpitt, Dwyer et al. 2011, Cornes, Joly et al. 2011). Without sufficient capabilities to pursue other (limited) opportunities for income generation, certain offending behaviours constituted the only other reasonable action alternative. Ravenhill (2012) suggests that within homeless cultures these behaviours can become normalised, as associates regularly engage in them. Situational action theory posits that as a particular action alternative is repeatedly selected in response to particular environmental inducements (e.g. encouragement from peers) an automatic choice process becomes more likely, establishing the behaviour as habit (see section 3.5).

With the exception of Arnie, Johnny and Joel, offending histories emerged after participants entered homeless situations. In turn, most participants offences were associated with ‘street culture’ either being theft related (n=5), anti-social behaviour related (n=4), or violent offences resulting from confrontations with other homeless associates (n=6). Four participants (Bev, Liam, Lenny, Lisa) reported no offences of this nature, although Lenny did regularly engage in begging throughout

his adult life. Arnie, Johnny and Joel were all imprisoned for repeated offences related to personal theft, commercial theft and handling stolen goods.

Of these participants, only six spent time in prison as a result of offending. Two were imprisoned for single sentences of one year or less (Joseph, Lyla), Linda was imprisoned on two occasions for a total of 3 years. Arnie and Johnny both spent between 5 – 10 years in prison as the culmination of numerous periods of incarceration. Joel spent the most time in prison of any participants, with a total of 15 years.

The variable nature of offending did not show any clear relationship between adverse relationships with parents and education, and propensity to engage in offending, as suggested by Wikström (2012)(see section 3.5.2)

Of course, these experiences are over the whole life course of participants, most had not been in prison for many years. In line with one of the accepted regularities of desistance literature, most of those participants who had offending histories reduced their offending as they moved into middle age (Kazemian, 2007). For example, Johnny had not been in prison for over 16 years. Joel (3 years ago) and Lyla (4 years ago) had the most recent prison sentences.

‘Street Culture’ Activities

<i>Table B.6: Incidence of ‘Street Culture Activities’ in Participants Life Histories</i>			
	Street Drinking and Drug Use	Begging	Regular Rough Sleeping ⁶⁵
Arnie	X	X	X
Bev	X		
Carl	X	X	X
Gary	X		
James	X	X	X

⁶⁵ ‘regular’ rough sleeping refers to participant’s subjective accounts of rough sleeping more than just a few involuntary incidents.

Table B.6 continued

Jimmy	X	X	X
Joel	X		X
Johnny	X		
Joseph	X	X	X
Liam	X	X	X
Lenny	X	X	X
Lisa	X	X	X
Linda	X		X
Lyla	X	X	X

In accordance with MEH literature (Fitzpatrick et al. 2011), ‘street culture’ activities were defined as participants’ engagement in rough sleeping, begging, or street drinking and drug use. Data was drawn from participants’ own accounts of their time spent homeless. Differences emerged in the extent of participant’s immersion in ‘street culture’.

As highlighted in table B.6, participants had engaged in street drinking and drug use, most commonly while in a homeless situation, albeit to varying degrees. All participants reported a culture of substance use in hostels but became immersed in this culture to varying degrees.

“I suppose I was gradually slipping back on one or two things, drink and things, but then, I was in [direct access hostel].”

(Johnny. Positive Trajectory)

“I had to get out of that, I had to get away from that crowd to get this [tenancy]. I had to get away from going crazy and doing all this stupid shit cos if I’d carried on I would have ended up in a hostel system for the rest of my life.”

(Gary. Fluctuating trajectory)

“We were hardened, hardened drinkers, dead simple. We baffled all the members of staff, we baffled everybody. However, we didn’t destroy the place, we didn’t do nothing.”

(Liam. Static Trajectory)

For example, Johnny and Gary were aware they were slipping into these behaviours and expressed trepidation, which led them to try to restrict their immersion. In contrast, Liam was representative of some other participants such as Lenny and Arnie who had become more immersed in these norms, developing close social bonds.

The majority of participants also engaged in begging behaviours (n=9) and regular rough sleeping (n=11). All those who engaged in begging also reported regular rough sleeping, demonstrating a greater degree of immersion in street culture than those who engaged in street substance use alone. As Lenny and Linda’s quotes demonstrate, even amongst those participants who reported regular rough sleeping, their immersion in the culture of rough sleeping differed. Linda chose to rough sleep on some occasions because of restrictions which prevented her from spending the night with her girlfriend.

“Yeah we both had beds in the foyer it was just so we could spend the night together”

(Linda. Fluctuating Trajectory)

For Lenny, rough sleeping was experienced much more regularly and involved a group of associates. In turn, the choice to rough sleep became habitual and normalised:

“I mean I’m used to sleeping in sleeping bags making little camps and that with me pals, down in sleeping bags we get cold we just snuggle in next to each other.”

(Lenny. Static Trajectory)

The extent of participants' immersion in street culture can also be established by exploring how long they described engaging in these activities. Four participants described comparatively limited immersion, only engaging in these activities for a few years (Bev, Lisa, Gary, Johnny). In turn, none of these participants engaged in all three activities. Linda and Joseph engaged in these behaviours for a longer period of time, around eight years. However, the majority of participants engaged in these behaviours for over ten years (Liam, Jimmy) with many spending much of their lives engaged in these behaviours (Arnie, James, Joel, Carl, Lyla, Lenny).

As with mental health issues and substance use issues, engagement in street culture activities has the potential to influence participants' capacity to make recovery and desistance orientated choices. As demonstrated in 5.4.6 and discussed further in 7.2.3, the influence of associates who had similar needs was overwhelmingly negative.

Participants who were more immersed described stronger relationships with others engaging in street culture activities. In turn, these local social networks can encourage a return to street culture by determining the norms of behaviour and by offering repeated temptation to engage in behaviours that conflict with long term, recovery based priorities (Wikstrom, 2004). In recovery and desistance literature (Dingle et al., 2015, Weaver & McNeill, 2015), as well as HF (Nelson et al., 2015) greater immersion in these networks has been suggested as a hindrance to successful pathways away from a range of harmful behaviours.

In turn, if participants are overly dependent on capabilities for making money (such as shoplifting or begging) which are classified as offences, they are also more likely to face criminal sanction. In contrast, those participants who possess other capabilities for making money such as employment or support from family have a

wider range of action alternatives available to them (Wooditch et al. 2013). Section B.2.2 considers the importance of ‘capabilities’ in the life history of participants further.

B.2.2: The Extent and Mastery of ‘Capabilities’ in Participant’s Life Histories

The extent to which relevant capabilities were developed in the life courses of participants’ illuminated inequities in participant’s capacity to reach subjectively desirable outcomes. Of course, the capabilities noted here are not presented as an exhaustive and complete list. In line with an analytical realist perspective, the capabilities selected are those deemed particularly relevant. Relevance was identified through the personal priorities of participants (see section 5.2), and from protective factors reported in HF and recovery and desistance literature more broadly⁶⁶. Generally, those participants with more capabilities had a greater range of experience to draw upon when making intertemporal choices in line with service outcomes and their own ‘ultimate’ priority outcomes

Education

Limited engagement with formal education is understood to be symptomatic of adverse childhood experiences and predictive of social exclusion later in the life course (Fitzpatrick & Bramley, 2015). In this study, participants’ educational engagement was discussed in three ways:

- Whether participants completed secondary school and whether they were permanently excluded from school;
- Whether they achieved any qualifications (which would offer them greater capabilities with which to gain employment);

⁶⁶ See section 2.6.3 and 3.5.2 under ‘The Capabilities of MEH actors’ for discussion of these factors

- Qualitative accounts of the extent to which participants' actually engaged with education/school

The first point to note is that very few participants (Jimmy, Joseph, Liam) reported positive engagement with education during childhood and adolescence. This finding is not surprising in the context of MEH adults, with other studies highlighting limited attainment and poor engagement (Fitzpatrick et al., 2012). Five participants (Bev, Gary, Jimmy, Joseph, Liam, Lisa) reported that they finished secondary school. However, Bev reported leaving school with no qualifications. The majority (n=11) noted poor engagement at school, with four being formally excluded on more than one occasion (Carl, Lyla, Linda). In addition, Joel, Arnie and Lenny were not formally excluded, but rarely attended school:

"I never went to school, can't read and write, can't use computers and I wish I could."

(Lenny. Static Trajectory)

"I don't know what it's like in your old school days but in my old school days ... you could get missing ... see one was checking from class to class."

(Joel. Fluctuating Trajectory)

Many of those who did not engage with secondary education described engagement in 'street culture' activities such as substance use and low level theft, either under the influence of associates or as a necessary 'survival crime':

"Aye, I left [special behavioural school] in year 9 though."

Interviewer: "In year 9, and what did you do then?"

"fuck all, drinking"

Interviewer: "Were there other people around where you were drinking or was it just you?"

"Aye, me pals and that"

Interviewer: "So did your pals start drinking the same time as you?"

"Well I've always like knocked around with people older than me."

(Linda. Fluctuating Trajectory)

“Since I was like 12/13 years old, I’ve been on the streets. I used to go to me aunties and uncles, but obviously they died. I had nothing, I had me older sister. I used to have to go out on me own, in the middle of the night and go robbing out of people’s gardens, out of people’s coal bunkers, just to put stuff in the cupboards, coal on the fire.”

(Lenny. Static Trajectory)

Whereas some individuals became involved in more serious and organised crime:

“It was ¾ million pounds worth of motorbikes, there was 28 of we involved so.. But anyway I went and got detention centre, 2 years after when I’d been arrested. When I got out of detention centres they put is in care, they took is off me mum ya nar. But not because she had done anything wrong, it was because I was a bit of a tearaway when I was a kid ya nar.”

(Joel. Fluctuating Trajectory)

In contrast, those participants who did engage more with education went on to develop other capabilities useful for pursuing recovery and desistance orientated outcomes. Educational engagement had longer lasting effects on their ability to recognise and adhere to wider social norms around behaviour (see section 3.5.3). Generally these individuals favoured pro social roles such as employment, over criminal behaviours.

Employment Experience

Employment is understood as gateway to further social inclusion, social capital and independence (Dwyer, 2004; Dwyer & Wright, 2014). Experience of formal employment, and particularly experiences of sustaining employment offer capabilities to return to future work, a point of reference of what work is like, and some level of understanding of how to adhere to social norms around behaviour. All of which can be seen as important components in enabling participants to reach their ultimate priorities.

Participants' experiences of employment were representative of those included in the 'Hard Edges' study of 'severe and multiple disadvantage' in England (Fitzpatrick & Bramley, 2015), with high levels of unemployment intersected by mostly short term, casual work common across participants life histories. Ten participants had some form of employment experience, with only Gary, Lenny, Lyla and Linda reporting no experience. However, the majority of participant's experience was short term, low paid, casual employment. For example, Arnie and Joel's total experiences of employment were each less than a year. For Bev, Carl, James and Lisa their employment experience lasted for 1 – 4 years in early adulthood, casual shop work for Lisa and Bev, and uncompleted joinery and roofing apprenticeships for Carl and James.

In contrast, Johnny, Jimmy, Joseph and Liam all had longer experiences of stable employment ranging from 8 to around 20 years. For Jimmy, Joseph and Liam these experiences preceded issues with homelessness, mental health, and substance misuse, albeit with some overlap. When combined with positive accounts of education, it is evident that for each of these participants much of their lives were spent engaging in pro social roles, and adhering to wider social norms, until significant 'negative' turning points emerged (Clapham, 2003). Johnny's experiences came before and after a decade spent in and out of prison and were later halted by his relationship breakdown and subsequent heroin addiction, differentiating him from Jimmy, Joseph, and Liam.

Tenancy Sustainment Experience

In a HF service that primarily utilises PRS accommodation, participants' capabilities around tenancy sustainment are likely to be important. Possessing the capability to manage a PRS tenancy effectively is particularly important in England where a high risk of PRS eviction exists (Fitzpatrick et al., 2017), especially when

housing offers such an important foundation for the wider pursuit of recovery and desistance (Clapham, 2010; King, 2003; Ornelas et al., 2014)⁶⁷.

Past experiences of tenancy sustainment are likely to offer participants a frame of reference for current choices and actions. This section explores both successful and unsuccessful periods of tenancy experience across the lives of participants. This highlights the prominence of homelessness and institutionalisation in participants' lives (Goodman et al., 1990; Lamb, 1993).

<i>Table B.7: Participant's experience of tenancy sustainment</i>			
No direct experience	< 1 year experience	2 – 5 years' experience	10+ years experience
Arnie, James, Lenny	Carl, Linda	Gary, Lyla, Joel, Lisa	Bev, Jimmy, Joseph, Johnny, Liam

There were clear differences in participant's experience of tenancy sustainment, as highlighted in table B.7. However, qualitative accounts highlighted variability in participant's personal capacity to complete all the tasks necessary in tenancy sustainment. Carl, Linda and Gary were all evicted from their independent tenancies within a year of entering them due to rent arrears, property damage and anti-social behaviour.

"Cos I had one of these, like a recliner, I was wrecked, a was bang on the bubble [mephedrone] then, and I left them to like party with me friend. I come back the next day and ya nar me recliner and all the bean bag was slashed and then noise pollution people came."

(Linda. Fluctuating Trajectory)

⁶⁷ See section 2.7.1 for discussion of the HF principle of 'immediate, independent housing', and section 5.4.2 for discussion of how participant's utilised housing as a foundation for the pursuit of other outcomes.

“My friend who was in and out of the tenancy had issues with probation, he was part of fraud ring and didn’t inform is, so I had to bring someone in illegally, sublet and through that I lost my house”

(Gary. Fluctuating Trajectory)

Furthermore, Jimmy and Joel both noted that although they experienced periods in which they were housed, their partners at the time had completed many of the tenancy sustainment tasks such as paying bills and rent. As such, these participants possessed less direct experience of how to independently carry out these tasks. Without internal representations (Wikstrom, 2014) on which to draw these participants are left with only environmental cues on which to base choices over tenancy maintenance tasks⁶⁸. However, it is still worth noting ‘unsuccessful tenancy experience’ because at least these participants could be considered as having some point of reference of what is required to maintain a tenancy.

Positive, subjectively supportive relationships

In participants’ life histories, two key types of subjectively positive relationships emerged as having the greatest influence on participants’ pathways: romantic relationships and relationships with family. Positive and supportive relationships are recognised as important protective factors in recovery and desistance literature (Topor et al., 2006; Walker et al., 2013) and in accounts of recovery in HF in particular (Patterson et al., 2013). In turn, those with the most complex experiences of severe and multiple disadvantage tend to have less sources of social support from family, friends and romantic relations (Fitzpatrick & Bramley, 2015).

Participants’ relationships with their families were diverse. Some expressed positive relationships with immediate and extended family (Joseph, Johnny, Lisa, Liam, Linda). Some expressed overwhelming negative relationships with family

⁶⁸ See section 3.5.1 for further discussion of internal representations.

(Arnie, Gary, Jimmy, Lenny, Lyla). For each of these participants, negative perspectives of family were rooted in experiences of abuse and neglect in childhood and later in life. As such, returning to these relationships is unlikely to support recovery or desistance (EnglandKennedy & Horton, 2011). The remaining participants expressed mixed perspectives. Carl and James both expressed poor relationships with parents but better relationships with extended family. Bev and Joel both had ongoing relationships with parents but these had been stressed over many years.

Eight participants still had subjectively positive relationships in place at the start of the study, but the nature of these varied. Some had ongoing relationships with extended family such as siblings (Jimmy, Liam, Joseph) or aunties (Carl). However, relationships with siblings could not be described as supportive, with only limited contact. The remaining participants had relationships with parents in place at the start of the study (Joel, Johnny, Lisa, Linda, Bev). However, Joel was largely reluctant to access support from his mother.

The majority of participants (n=10) had experienced subjectively positive romantic relationships in their lives. Some had contributed to periods of abstinence and represented positive periods in participants' lives.

"I went to Sunderland where I met my second wife, she was the best thing that ever happened to me. I came off the drink, came off the drink for 18 months"

(Jimmy. Static Trajectory)

However, most romantic relationships were experienced in young adulthood and middle age and all but Linda were no longer in relationships at the start of the study. In turn, relationship breakdown had been a key contributor to the onset or worsening of participant's issues for the remainder of participants.

B.3: Situational Vignettes

Analysis in volume one of thesis has focused on factors relating to participant's personal histories or their setting (environment). Chapter 7 began to draw these factors together by highlighting how personal histories largely predicted the type and nature of environmental factors influencing participant's situational capacity to make intertemporal choices towards recovery and desistance orientated outcomes. This section draws out a couple of key 'turning points' in individual participant's trajectories to illuminate the strength of a situational approach in understanding why individuals engaged in particular actions, which had significant consequences. Analysing these turning points is widely promoted amongst enquiries into causal pathways and rationality (Somerville & Bengtsson, 2002; Clapham, 2003). The first analysis focuses on an action which had negative consequences, and the second focuses on an action which had positive consequences.

B.3.1: Joel – 'Police at the Door'

Joel's trajectory was on a largely positive trend before a critical juncture at which he was arrested and imprisoned:

"Aye, but d'you know like, before I got arrested I was living a totally normal life, I was starting to buckle down again, you know there was a little bit of daftness in the first few month but, you know it takes an awful long time for somebody to settle again and its gonna take an awful long time this time again."

In line with a 'pathways' approach (Clapham, 2003)⁶⁹, we can understand the point at which Joel was arrested as a key turning point in his trajectory. As well as offering a broad framework for enquiry into the factors influencing participant's

⁶⁹ See section 3.6 for an outline of a 'pathways approach' and section 4.1.4 for an outline of how it was used in this study

capacity for choice, a situational approach has particular strength in understanding individual choices which have significant long term consequences.

As highlighted in section 3.4, an actor's subjective perception of a situation is of central importance when understanding why they have chosen a particular course of action. An interpretive approach is required by the researcher, but the actor's own description of the situation is invaluable⁷⁰. Joel gave his version of his arrest in parts, I will therefore begin by offering a brief summary of the event, based on conversations with Joel, and his case manager.

The police came to Joel's door with a warrant to search his property for stolen goods. At which point Joel was accused (and subsequently found guilty) of threatening them with a weapon, before fleeing his property and being arrested the next day. Joel offers a more detailed description of his thought process at the time:

"I slammed the door in their face ... But let's face it Chris, I blew my top with them, so what? You do if people start antagonising ya, I'm not bothered if they're police or not ... What would they have done if I had just let them in for those warrants? Would they just have antagonised is in me own premises? Cos I had a lot of implements in me house, so they would have nicked is anyway. Then I would have kicked off and they would have hit is with affray in the streets. I had no chance that day, and that's why I bolted. It sound sensible doesn't it?"

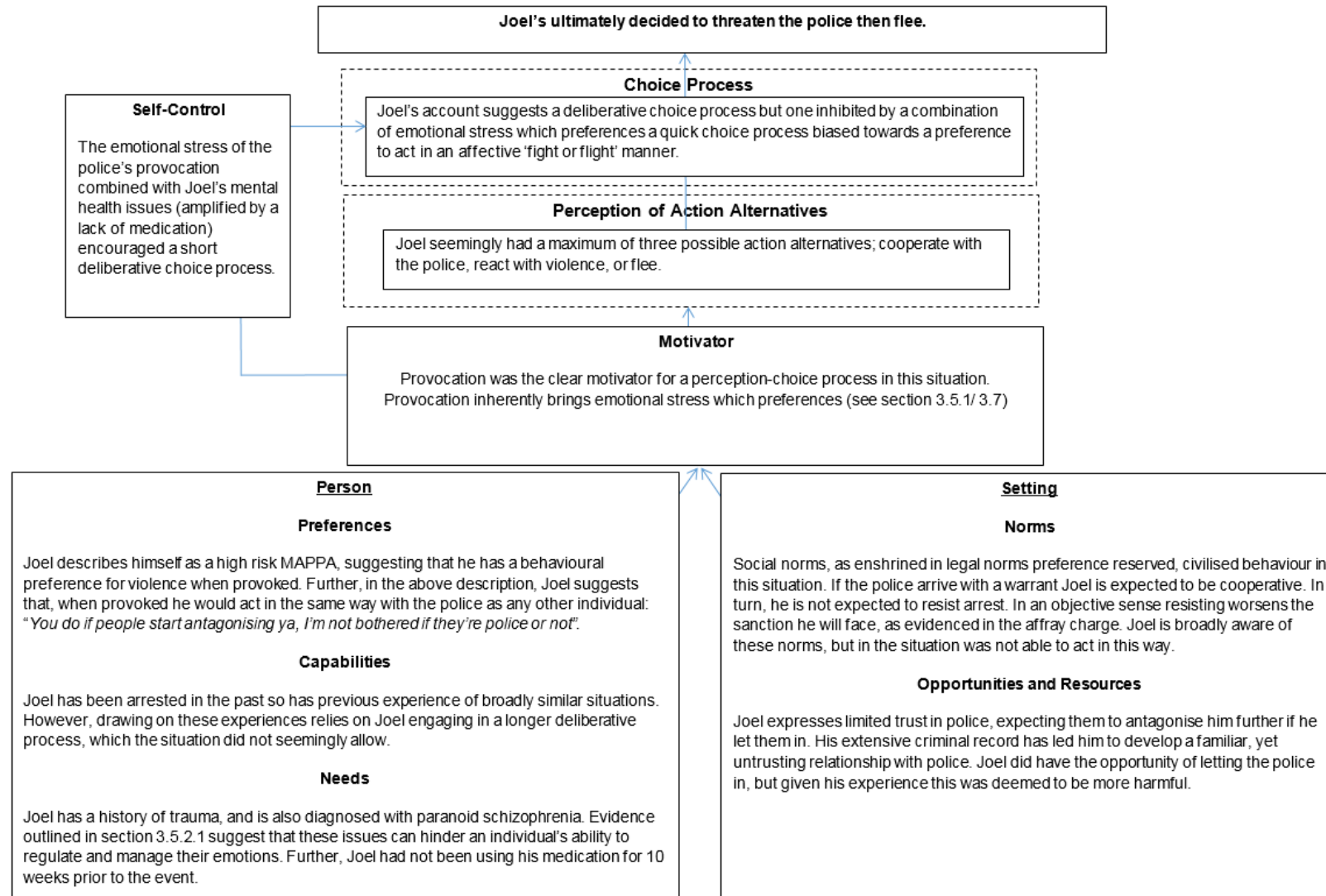
"Well they charged is 3 times you know, with different things, charging is with. They NFA'ed (no further action) the warrants, [they] hit is with threats to kill, dropped the threats to kill, then hit is with affray because they know affray has got more time in prison than threats to kill, and the threats to kill's got more time in prison than for an NFA (no further action) ... So why did they even come to me house? me house wasn't even searched."

Joel offers a detailed description of his perception of the situation. A situational analysis can illuminate the rationality behind his decision to threaten the

⁷⁰ See section 4.1.2 for discussion of the importance of interpretivism in this study

police before fleeing. The diagram below offers a diagrammatic representation of a situational analysis.

Figure B.1: Situational Analysis of Key Turning Point for Joel



Through a situational approach, it is possible to understand that a number of personal and setting based factors combined to both lead Joel to an understandable course of action. However, these factors also led to significant negative consequences for Joel's recovery and desistance trajectory. Joel was later arrested and experienced five months in prison. As a result, Joel's benefits were stopped and he was unable to pay rent. Joel was forced to give up his property to avoid further rent arrears. The HF service helped to clear out his tenancy and his case manager visited him in prison. Joel was released on a suspended sentence for affray to his mother's address. However, his lifestyle was causing strain on their relationship and Joel moved out. After my final interview, Joel was rough sleeping again, his mental health had worsened, and his drug use had increased. However, he has just begun to re-engage with the Multiple Exclusion service and was expressing a desire for another HF property.

B.3.2: Bev – 'Splitting up with partner'

Bev's wider trajectory is discussed in figure 5.2 (section 5.3.1 of volume one). This analysis focuses solely on Bev's decision to separate from her boyfriend. This decision represented a key 'turning point' in Bev's trajectory, enabling her to achieve her ultimate personal priority of seeing her children more regularly. While in her first HF property, Bev's partner was living with her and encourage higher levels of alcohol use, as well as provoking arguments which often manifested in violence and damage to the property. Issues with damp in the property encouraged Bev's case managers to negotiate a move to an area closer to her parents, where her children were living. In a similar manner to Joel, Bev's account was offered sporadically throughout an interview. Bev's account below offers insight into Bev's perception of the split and her rationale for doing so.

"Interviewer: Is it easier for your daughters to stay in this place than the last place? It was all because of [ex-partner] ... Normally I'd be asking me mam and she'd say no.

Interviewer: Your mam wouldn't want them to come around when [ex-partner] was in the last place?

No. She wouldn't approve. It's just cos of everything else that went on and that ... he's got the message now. I met him Saturday night ... That's the first time I've seen him in all this time ya nar. I was sitting with me brother. Went up [area in North Tyneside] when I got back, got some cans and that. He went he will ring, he will ring! I went nar it's been over 3 weeks now, ah, there goes the phone. I went on the Saturday and had a few drinks and I said I'll speak to ya but, it was alright aye ... I didn't really talk to him much to be honest. I just had a couple drinks, then I came home. He went to get his tenner deal cos he had a tenner left. I went [ex-partner] go and get your tenner deal and I'll go home."

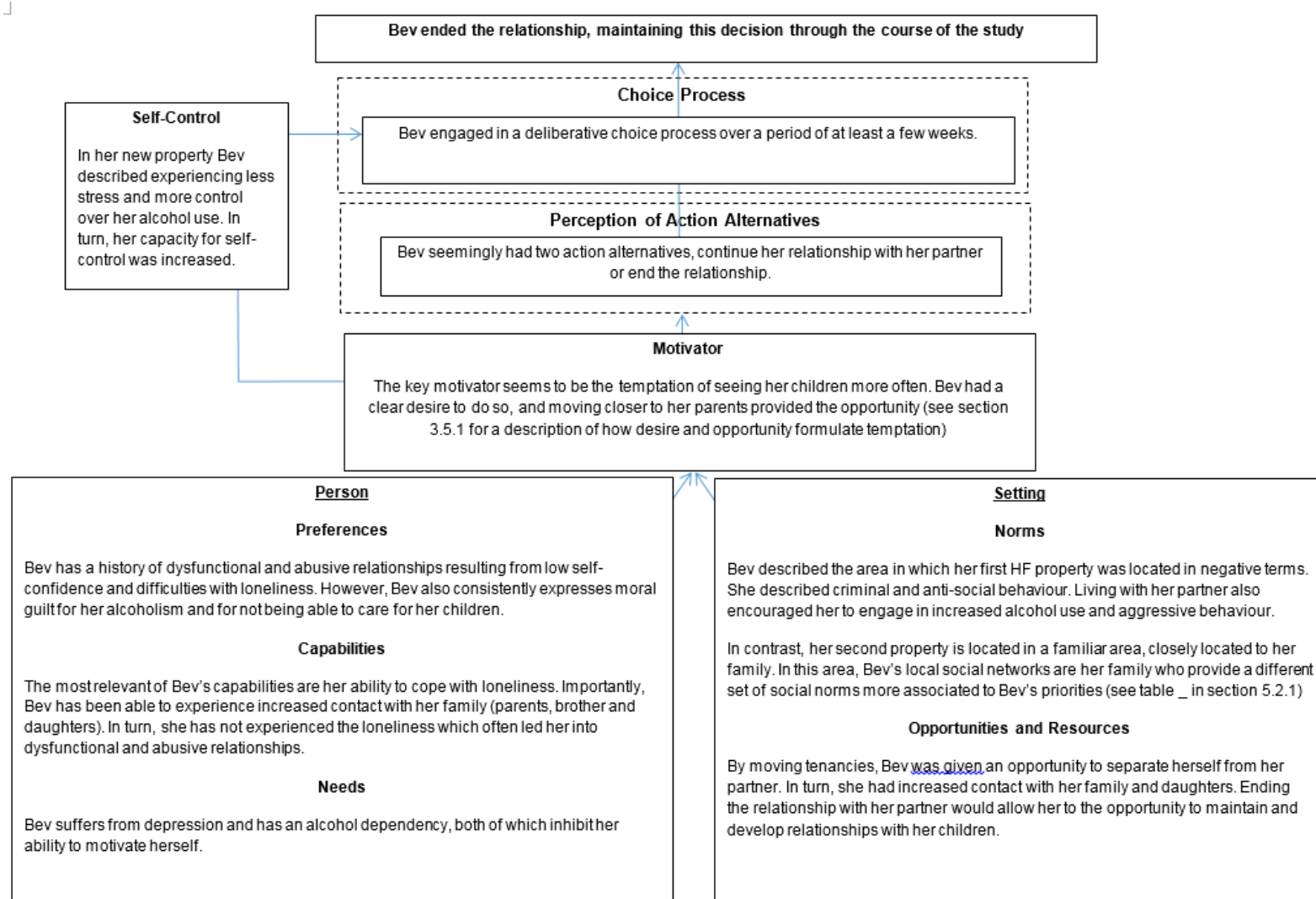
"Interviewer: Can you rely on your family if anything was to go wrong?

Yeah, my dad's always like that, he'll come and fix something that's not even broken!

I like it though, cos when I lived just along the road in Shields, it was like too much, but now it's a little bit of a distance.

Abby's only stayed once since I've moved in here but Caitlin's stayed a few times. But the last time she stayed, I think it was last Sunday, no the Sunday before ... She's got her own cupboard."

Figure B.2: Situational Analysis of Key Turning Point for Bev



Bev's decision differs from Joel's significantly, perhaps the most important situational factor which is not noted in the diagram above is time. Bev had significantly longer time to consider her decision than Joel, who was forced to respond quickly in a particular circumstance. In turn, although both are understood to have engaged in deliberative choice processes, a great deal of difference exists.

Bev's change in tenancy was seemingly essential in providing the opportunity to escape a relationship which had negative consequences for Bev's trajectory. This opportunity was mediated by a positive shift in Bev's local social network, social norms, and capabilities to manage loneliness through support from her family. This shift in norms also gave greater prominence to her ultimate preference for greater contact with her children, and allowed better management of her depression and alcohol use. In turn, she was able to exercise sufficient self-control to inhibit the desire to be in a relationship with her partner.

The longer term consequences were increased contact with her family and more control over her alcohol use. In turn, she has experienced less provocation from her ex-partner. Bev's example demonstrates the importance of enabling HF clients the choice to move property in order to catalyse positive change. Further this example, re-affirms the integral role of positive, supportive social networks, as well as the potentially damaging impact of those that exacerbate needs.

Appendix C

- C.1: 'Easy Read' Participant Information and Consent Forms
- C.2: Client Participant Topic Guides
- C.3: Stakeholder Participant Topic Guides

C.1: 'Easy Read' Participant Information Form

Housing First Newcastle - Service Evaluation

Background

Chris Parker, a PhD student from Northumbria University is carrying out an evaluation of the Housing First service ran by Changing Lives in Newcastle upon Tyne.

The main aims of the evaluation are:

- To find out what helps people to succeed or what leads to people being unsuccessful in the Housing First service in Newcastle and how this changes over time.
- To look at whether having choice and control over housing, support and behaviour is important in succeeding in Housing First and how this changes over time.

The project will have two main parts:

Part 1: Interviews

The main part of the evaluation will be 3 face to face interviews over a year with clients of Housing First. These will let us find out whether people are happy or unhappy with service.

When will the interviews take place?

The interviews will take place 3 times over a year and **will last around 1 hour**. There are 3 interviews to see how things have changed over time.

- The first interview will take place in **June - August 2015**
- The second interview will take place in **January 2016 – April 2016**
- The third interview will take place in **July - August 2016**.

Where will the interviews take place?

You will choose whether the interviews take place in private room at **Ron Eager House** or at your home.

If they take place at your home then your support worker will also be there.

What will I be asked?

First Interview

In the first interview you will be asked about your life before you entered Housing First. This will let us see how things have changed since you started in Housing First. You will also be asked what your goals are for the future so we can see how Housing First helps you reach these goals.

Second and Third Interviews

In the second and third interviews you will be asked about how your life is going while in the Housing First service. You will also be asked about the service and how much choice and control you think you have. We will also discuss the goals you mentioned in the first interview and see whether these have been reached or have changed.

Biographical Interviews

Over the three interviews we would also like to gather information about your past. These will help to get an idea of the challenges you may face individually as well as how you may be equipped for independent living.

Part 2: Observations

If you both agree, the researcher (Chris) will sit in on one of your meetings to see what you talk about and how you make decisions about things (like what support you need).

When will the observations take place?

There will just be **one observation** of you and your support worker and this will take place around the same time as the second interview in **December 2015 or January 2016**.

Where will the observations take place?

The observations will take place wherever you and your support worker meet.

Taking part in the Evaluation

You do not have to take part in the survey. But if you do agree to take part you will be given this information sheet to keep. You will also need to sign a **consent form**.

Consent form

This is a form that says you agree that your details can be used in the research and that you are happy to be interviewed.

You do not have to take part in all parts of the evaluation.

You can choose to take part in

Part 1: Interviews

Part 2: Observation

Or you can choose to take part in both.

If you choose to take part in the interviews you don't have to take part in all 3 interview, You can decide before each interview whether you want to take part.

Questions and Concerns

If you have any questions about the research please contact:

Christopher Parker

PhD Researcher

Department of Social Sciences and Languages

Northumbria University

NE1 8ST

Email: Christopher.parker@northumbria.ac.uk

If you have any concerns or want to make a complaint about the research please contact:

Wendy Dyer

Faculty Ethics Director

Northumbria University

NE1 8ST

Email: wendy.dyer@northumbria.ac.uk

HOUSING FIRST EVALUATION

Consent Form

Part 1: Taking part in an interview and updates from support worker

Client Name	
Case Manager Name	

I have read and understand the information sheet and I am happy to take part in an interview at stage 2.

I also agree that I am happy for information about my progress to be discussed between my support worker and the researcher.

I have been told that any information you get from the research will be kept private by Northumbria University.

I know that all interview recordings and any written notes will be kept private, and only the research team will be able to use them.

Please sign and date the form if you want to take part in a face-to-face interview.

Signature_____

Date_____

HOUSING FIRST EVALUATION

Consent Form

Part 2: Taking part in an observation

Client Name	
Case Manager Name	

I have read and understand the information sheet and I am happy to take part in an observation.

I have been told that any information you get from the research will be kept private by Northumbria University.

I know that all observation recordings and any written notes will be kept private, and only the research team will be able to use them.

Please sign and date the form if you want to take part in a observation.

Signature_____

Date_____

C.2: Client Participant Topic Guides

C.2.1 : Wave 1 – Client Participant Topic Guide

Introduction

I would like you to take part in this piece of research because we want to find out as much as possible about the lives of the people involved in Housing First. We would be very grateful if we could talk to you for around one hour. You can end the interview at any time that you want to and can leave out any questions that you would prefer not to answer.

I would like to record the interview, but can make written notes if you would prefer me to. The recording will be written down by me at Northumbria University. Nothing will ever be said or written that would mean that you could be identified as someone who took part in the research. If you would like to see a written record of the interview once it has been produced, I can arrange for that to happen.

- *Explain Research and Aims via research information form.*
- *Ensure participant fully understands all information provided on research information form.*
- *Ask participant to sign 2 x consent form (1 x participant, 1 x researcher)*

Treatment and Housing Choice

Firstly I'd like to discuss your current situation and the Housing First service. In particular I'd like to discuss how you make decisions.

Support/Treatment

When did you start working with the Housing First team?

What were your reasons for going in to Housing First?

How often do you see your case manager?

How do you decide when you see your case manager?

What have you worked on with them so far? Who decided to work on that? (PROBE FOR WHO BROUGHT UP IDEA)

If you've worked with them when not in your own place, is it different? (PROBE FOR HOW MEETINGS GO, WHAT THEY WORK ON, WHERE THEY MEET)

[IF YES] How would you say it's different?

Housing

How did you make the decision about which flat/apartment to enter? (PROBE FOR CHOICE OVER HOUSING TYPE AND NUMBER OF OPTIONS AVAILABLE)

How long did it take to find a flat after you starting working on it? (IF MORE THAN 2 MONTHS)
Why did it take this long?

Did you ever feel like you would have your own independent flat when you were homeless?
Did you choose to live in this particular area? IF YES why did you choose this area? IF NO How did you come to live here?

Who did you work with to make this decision? Are they the only person you work with in this service?

Were there any requirements and or anything you had to agree to before getting your flat?

How do you feel about your new flat/apartment? (HAPPY, EXCITED, SCARED)

Could you tell me more about why you feel this way?

How much do you feel your priorities have been considered in choosing this flat?

Could you tell me more about why you feel this way?

How do you feel inside your current property?

Does it feel like home?

Why do you feel this way?

Neighbourhood

Have you been out in your neighbourhood much?

IF YES, Where do you go?

How did you feel when you went out?

Do you see this as a good neighbourhood? Why do you feel that way?

Do you feel there is a sense of community here? Why do you feel that way?

How do you feel about the area you live in generally?

Is there much to do around here? (PROBE FOR PLACES TO SOCIALISE, ACTIVITIES, PARKS)

IF NO, Why haven't you been out? Is there anything which has stopped you?

Have you met any neighbours? IF YES, Have you spoken to them more than once?

Do they seem nice to you? What kind of people are they? (PROBE FOR AGE, MARRIED/SINGLE, FRIENDLY/CLOSED)

IF NO, Why not? (PROBE FOR REASONS AND FEELINGS OF ISOLATION)

Homeless vs housed experiences

What are the main differences between your life before you got your own flat and after?

How would you compare your sense of choice and freedom now to when you were in a hostel/ rough sleeping?

Do you feel you have more or less choice and freedom?

Could you tell me more about why you feel this way?

Do you feel you have more or less control over your life?

Do you feel you have more or less choice and freedom?

Could you tell me more about why you feel this way?

Choice

To what extent do you feel your priorities are considered in deciding what support you access?

Can you refuse support? (IF YES) What happens if you refuse support?

Family/ Relationships/Social Networks

Who can you really count on to listen to you? (PROBE FOR WHETHER INFORMAL FAMILIAL SUPPORT OR PROFESSIONAL AND SITUATIONAL DIFFERENCES)

Who could you call on to help you in a crisis? (PROBE FOR WHETHER INFORMAL FAMILIAL SUPPORT OR PROFESSIONAL)

Do you have any family who would be willing to help you in a time of difficulty? (IF YES) Could you tell me who they are and what type of help they could provide you with?

Visitors

Have you had any visitors/ friends round to the flat?

IF YES, How were these visits? How did you feel when they visited? (PROUD, ANXIOUS, PROTECTIVE OVER THE FLAT?)

IF NO, Are there any particular reasons for this? (PROBE FOR WHETHER ADVISED AGAINST THIS OR NOT ALLOWED VISITORS?)

Are there any friends you wouldn't invite round? IF YES, Could you tell me why?

How would you compare your sense of choice and freedom in a flat with when you were homeless?

Could you give me reasons for this?

Quality of Life, Subjective Health and Subjective Wellbeing

I'd like cover some general questions which allow me to gather how you feel about your quality of life, health and sense of wellbeing. For each of these questions I will read out the question then the choices of response. If you would like me to repeat a question please just say so

How would you rate your current quality of life?

1	2	3	4	5
Very Poor	Poor	Neither poor nor good	Good	Very good

Could you give me reasons for your response?

All things considered how satisfied are you with your life as a whole?

1 Very Dissatisfied	2 Dissatisfied	3 Neither dissatisfied nor satisfied	4 Satisfied	5 Very satisfied
------------------------	-------------------	---	----------------	---------------------

How would you rate your current health?

1 Very Poor	2 Poor	3 Neither poor nor good	4 Good	5 Very Good
----------------	-----------	-------------------------------	-----------	----------------

Social Trust Question

Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people? Please give a score of 0 to 10, where 0 means you can't be too careful and 10 means that most people can be trusted.

Can't be too careful 0	1	2	3	4	5	6	7	8	9	Most people can be trusted 10
-------------------------------------	---	---	---	---	---	---	---	---	---	---

SWEMWBS (Short Warwick Edinburgh Mental Wellbeing Scale)

Now I'd like you to respond to some statements about feelings and thoughts. Please choose the answer that best describes your experience of each over the last two weeks.

Read out statement and repeat response options after each statement is read out.

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my mind about things					

Perception and level of choice

Pearlin and Schooler Mastery Scale

I'd now like to look at your level of mastery or control over your life. I have 7 questions, each of which I'd like you to answer on a four point scale from 'strongly agree' (1) to 'strongly disagree'(4).

Statements	1 'Strongly Agree'	2 'Agree'	3 'Disagree'	4 'Strongly Disagree'
There is really no way I can solve some of the problems I have				
Sometimes I feel that I'm pushed about in life				
I have little control over the things that happen to me				
RC - I can do just about anything I really set my mind to				
I often feel helpless in dealing the with problems of my life				
RC - What happens to me in the future mostly depends on me				
There is little I can do to change many of the important things in my life				

Outcome priorities

Finally, I'd like to gather some more information about your priorities for the future and what you want to get out of Housing First. The idea is that I will come back in 6 months and 12 months and see if these have changed and whether you have moved any further towards these.

Now you have started in Housing First what do you see as your personal priorities going forward?
(IF REQUIRED PROBE GENTLY FOR HEALTH, GENERAL WELLBEING, SUBSTANCE ABUSE, SOCIAL CONNECTIONS, FAMILY, MEANINGFUL ACTIVITIES, EMPLOYMENT)

Where do you see yourself in 6 months?

Where do you see yourself in 12 months?

Could you rate which of these priorities is most important for you?

Why do you rate these priorities in this way? (PROBE FOR WHY ONE IS GIVEN GREATEST 'WEIGHT')

Realistically, do you think this might happen?

What help would be most useful to you over the next 6 months to help you achieve this?

What might stop this from happening?

Have you been asked about your goals for the future before? By who? Did they use any tools/resources to help you identify goals?

(FOR CLIENTS WHO HAVE BEEN IN A HOUSING FIRST PROPERTY FOR 3 MONTHS)

Did you have goals for yourself or your life when you entered Housing First?

Have you reached any of these goals?

Are there any of these goals you haven't reached?

Could you tell me why you think that is?

Have your personal priorities changed since then?

C.2.2 : Wave 2 – Client Participant Topic Guide

Introduction

Thank you for agreeing to take part in a second interview. Just to reiterate the purpose of the research is to find out as much as possible about the lives of the people involved in Housing First. We would be very grateful if we could talk to you again for around one hour. You can end the interview at any time that you want to and can leave out any questions that you would prefer not to answer.

I would like to record the interview, but can make written notes if you would prefer me to. The recording will be written down by me at Northumbria University. Nothing will ever be said or written that would mean that you could be identified as someone who took part in the research. If you would like to see a written record of the interview once it has been produced, I can arrange for that to happen.

- *Explain Research and Aims via research information form.*
- *Ensure participant fully understands all information provided on research information form.*
- *Ask participant to sign 2 x consent form (1 x participant, 1 x researcher)*

Housing and Community

Housing

Do you feel at home in your flat?

IF YES. What has helped it feel this way? (PROBE FURNITURE, LOCATION, SECURITY, FAMILY, FRIENDS, NEIGHBOURS)

Do you feel different to when you first moved in? How is it different?

How do you find organising your bills, rent and other expenses? (PROBE FOR WHETHER ORGANISED BY SELF, SERVICE OR IN COLLABORATION)

IF IN COLLABORATION, How do you plan budgets together?

How difficult do you find budgeting for these at first?

Have you had any problems with the flat over the past 6 months?

IF YES, How did you deal with these? Did you receive any support with this? (PROBE FOR WHO)

Visitors

Have you had any visitors/ friends round to the flat?

IF YES, How were these visits? How did you feel when they visited? (PROUD, ANXIOUS, PROTECTIVE OVER THE FLAT?)

IF NO, Are there any particular reasons for this? (PROBE FOR WHETHER ADVISED AGAINST THIS OR NOT ALLOWED VISITORS?)

Are there any friends you wouldn't invite round? IF YES, Could you tell me why?

How would you compare your sense of choice and freedom in a flat with when you were homeless?

Could you give me reasons for this?

Family/ Relationships/Social Networks

Who can you really count on to listen to you? (PROBE FOR WHETHER INFORMAL FAMILIAL SUPPORT OR PROFESSIONAL AND SITUATIONAL DIFFERENCES)

Who could you call on to help you in a crisis? (PROBE FOR WHETHER INFORMAL FAMILIAL SUPPORT OR PROFESSIONAL)

Do you have any family who would be willing to help you in a time of difficulty? (IF YES) Could you tell me who they are and what type of help they could provide you with?

Have your relationships with your family changed since we last met?

IF YES, How have they changed? Which family members have they changed with?

How do you feel about how these relationships have changed?

Have you made any new friends over the last 6 months? (IF YES) Where do you know these friends from? How long have you been friends with them? Would your friends be willing to help you in a time of difficulty? IF YES could you tell me what type of help they could provide you with?

(IF PEOPLE HAVE FRIENDS WHO ARE NOT HOMELESS) How often do you see your friends?

Do you see many of your friends from when you were rough sleeping/in hostels? How often do you see these friends? (PROBE FOR MORE, LESS, SAME AS WHEN HOMELESS)

IF JUST SOME, Why do you see these friends and not others?

Support/Treatment

How is your relationship with your case manager?

What kind of things have they been helping you with recently?

Have any problems arose in your relationship with your case manager?

Neighbourhood

Do you go out in your neighbourhood much?

IF YES, Where do you go?

How do you feel when you go out?

Do you see the area as a good neighbourhood? Why do you feel that way?

How do you feel about the area you live in generally?

Is there much to do around here? (PROBE FOR PLACES TO SOCIALISE, ACTIVITIES, PARKS)

IF NO, Why haven't you been out? Is there anything which has stopped you?

What are the people like around where you lived? (PROBE FOR NORMS OF AREA)

Have you met any neighbours? IF YES, Have you spoken to them more than once?

Did they seem nice to you? What kind of people are they? (PROBE FOR AGE, MARRIED/SINGLE, FRIENDLY/CLOSED)

IF NO, Why not? (PROBE FOR REASONS AND FEELINGS OF ISOLATION)

Have you ever faced any stigma or discrimination in accessing non homeless services or in trying to integrate into your community? (PROBE DOCTORS ETC)

Domains

I'd like to talk more specifically about different areas of your life which we identified in our first interviews. These questions are open and so do not have set responses for you to choose from. Instead I'd like to invite you to talk more freely in your responses.

Health

How is your physical health currently? How would you compare your health now to six months ago? [IF CHANGE] what were the main reasons for this change?

Have you consciously tried to improve your health?

Has your change in living situation improved your health?

How is your mental health currently? How would you compare your mental health now to six months ago? [IF CHANGE] what were the main reasons for this change?

Have you experienced any issues of depression or anxiety since we last spoke?

IF YES, Can you say why you felt this way? (PROBE FOR PROBLEMS RELATED TO MOVING INTO HOUSING FIRST)

[IF SELF HARM HISTORY] Have you had any instances of self harming since we last spoke? What were the reasons for this?

Education and Training

Have you been involved in any education or training since we last spoke or would you like to be in the near future? If so, please could you tell me more about this?

Income/Debt/ Benefits

Have you experienced any new financial difficulties since we last spoke?

IF YES, could you tell me about these difficulties?

Did you receive any support during this period? Who did you receive support from? Was it useful?

IF IN RECEIPT OF BENEFITS, Have there been any periods since we last spoke at which your benefits have been stopped? (APART FROM BEING IN PRISON)

Can you tell me why this happened?

What effect did this have on you? (PROBE FOR IMPACT ON SECURITY OF TENANCY, AND MENTAL HEALTH IMPACTS)

IF YES, Did you receive any support during this period?

Who did you receive support from? Was it useful?

Drug and Alcohol

Has your drug use changed at all since we last spoke? [INCREASED/DECREASED or TYPE OF DRUG or SOCIAL/INDIVIDUAL]

How do you feel about managing you drug use currently? Has there been any changes with this?

Do you consider yourself to have a drug problem?

Why do you take drugs?

What is your current alcohol consumption ?

Has your alcohol consumption changed at all over the last 6 months?[INCREASED/DECREASED or TYPE OF ALCOHOL or SOCIAL/INDIVIDUAL]

How do you feel about managing you alcohol consumption currently? Has there been any changes with this?

Criminal behaviour/ convictions

Please note: if you tell me about any crime that is not yet known to the police, I will have to pass the information on – these questions are about any offence for which you have a criminal record.

Have you committed any crimes over the past 6 months? [IF YES] Could you tell me about this? (PROBE FOR LOCATION, WHO WAS INVOLVED, WHICH KIND OF CRIME)

Why did you commit this crime?

Have you been a victim of crime in the past 6 months? [IF YES] Could you tell me about this? (PROBE FOR LOCATION, WHO WAS INVOLVED, WHICH KIND OF CRIME)

Street Culture Activities

Have you spent any nights away from your flat? IF YES, Where did you spend these?

Have you rough slept at any point since we last spoke? IF YES, could you give me your reasons for this?

Have you engaged in any begging or street drinking Since we last spoke? IF YES, could you give me your reasons for this?

Outcome priorities

Explore respondent's outcome priorities – cover each and explore;

- whether they feel they have achieved them?
- whether they feel that they have moved towards them?
- If they have achieved or moved towards how and what/who has contributed?
- if they have not achieved or moved towards why and what/who has contributed?

How far have you been able to guide your support towards these priorities?

Do you think you will achieve your goals?

What do you feel will stop your reaching your priorities/goals?

How has being in a property helped?

Quality of Life, Subjective Health and Subjective Wellbeing

I'd like cover the same general questions which we did at the start of our last interview. These questions will allow me to gather how you feel about your quality of life, health and sense of wellbeing. For each of these questions I will read out the question, the options for responding and ask you for your reasons for your response.

How would you rate your current quality of life?

1	2	3	4	5
Very Poor	Poor	Neither poor nor good	Good	Very good

Could you give me reasons for your response?

All things considered how satisfied are you with your life as a whole?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neither dissatisfied nor satisfied	Satisfied	Very satisfied

Could you give me reasons for your response?

How would you rate your current health?

1	2	3	4	5
Very Poor	Poor	Neither poor nor good	Good	Very Good

Could you give me reasons for your response?

Social Trust Question

Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people? Please give a score of 0 to 10, where 0 means you can't be too careful and 10 means that most people can be trusted.

Can't be too careful 0	1	2	3	4	5	6	7	8	9	Most people can be trusted 10
---------------------------	---	---	---	---	---	---	---	---	---	----------------------------------

Could you give me reasons for your response?

SWEMWBS (Short Warwick Edinburgh Mental Wellbeing Scale)

Now I'd like you to respond to some statements about feelings and thoughts. Please choose the answer that best describes your experience of each over the last two weeks.

Read out statement and repeat response options after each statement is read out.

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					

I've been able to make up my mind about things					

Perception and level of choice

Pearlin and Schooler Mastery Scale

I'd now like to look at your level of mastery or control over your life. I have 7 questions, each of which I'd like you to answer on a four point scale from 'strongly agree' (1) to 'strongly disagree'(4).

Statements	1 ‘Strongly Agree’	2 ‘Agree’	3 ‘Disagree’	4 ‘Strongly Disagree’
There is really no way I can solve some of the problems I have				
Sometimes I feel that I'm pushed about in life				
I have little control over the things that happen to me				
RC - I can do just about anything I really set my mind to				
I often feel helpless in dealing the with problems of my life				
RC - What happens to me in the future mostly depends on me				
There is little I can do to change many of the important things in my life				

C.2.3 : Wave 3 – Client Participant Topic Guide

Introduction

Thank you for agreeing to take part in a third interview. Just to reiterate the purpose of the research is to find out as much as possible about the lives of the people involved in Housing First. We would be very grateful if we could talk to you again for around one hour. You can end the interview at any time that you want to and can leave out any questions that you would prefer not to answer.

I would like to record the interview, but can make written notes if you would prefer me to. The recording will be written down by me at Northumbria University. Nothing will ever be said or written that would mean that you could be identified as someone who took part in the research. If you would like to see a written record of the interview once it has been produced, I can arrange for that to happen.

- *Explain Research and Aims via research information form.*
- *Ensure participant fully understands all information provided on research information form.*
- *Ask participant to sign 2 x consent form (1 x participant, 1 x researcher)*

Housing and Community

Housing

Does your flat feel like home?

IF YES. What has helped it feel this way? (PROBE FURNITURE, LOCATION, SECURITY, FAMILY, FRIENDS, NEIGHBOURS)

Do you feel different to when you first moved in? How is it different?

How do you find organising your bills, rent and other expenses? (PROBE FOR WHETHER ORGANISED BY SELF, SERVICE OR IN COLLABORATION)

IF IN COLLABORATION, How do you plan budgets together?

How difficult did you find budgeting for these at first?

Have you had any problems with the flat since we last spoke

IF YES, How did you deal with these? Did you receive any support with this? (PROBE FOR WHO)

Neighbourhood

Have you been out in your neighbourhood much?

IF YES, Where do you go?

How did you feel when you went out?

Do you see this as a good neighbourhood? Why do you feel that way?

How do you feel about the area you live in generally?

Is there much to do around here? (PROBE FOR PLACES TO SOCIALISE, ACTIVITIES, PARKS)

IF NO, Why haven't you been out? Is there anything which has stopped you?

What are the people like around here? (PROBE FOR NORMS OF AREA)

Have you met any neighbours? IF YES, Have you spoken to them more than once?

Do they seem nice to you? What kind of people are they? (PROBE FOR AGE, MARRIED/SINGLE, FRIENDLY/CLOSED)

IF NO, Why not? (PROBE FOR REASONS AND FEELINGS OF ISOLATION)

Have you ever faced any stigma or discrimination in accessing non homeless services or in trying to integrate into your community? (PROBE DOCTORS, POLICE ETC)

Family/ Relationships/Social Networks

Use social networks form to complete

Who can you really count on to listen to you? (PROBE FOR WHETHER INFORMAL FAMILIAL SUPPORT OR PROFESSIONAL AND SITUATIONAL DIFFERENCES)

Who could you call on to help you in a crisis? (PROBE FOR WHETHER INFORMAL FAMILIAL SUPPORT OR PROFESSIONAL)

Do you have any family who would be willing to help you in a time of difficulty? (IF YES) Could you tell me who they are and what type of help they could provide you with?

Have your relationships with your family changed since we last met?

IF YES, How have they changed? Which family members have they changed with?

How do you feel about how these relationships have changed?

Have you made any new friends over the last 6 months? (IF YES) Where do you know these friends from? How long have you been friends with them? Would your friends be willing to help you in a time of difficulty? IF YES could you tell me what type of help they could provide you with?

(IF PEOPLE HAVE FRIENDS WHO ARE NOT HOMELESS) How often do you see your friends?

Do you see many of your friends from when you were rough sleeping/in hostels? How often do you see these friends? (PROBE FOR MORE, LESS, SAME AS WHEN HOMELESS)

IF JUST SOME, Why do you see these friends and not others?

Visitors

Have you had any visitors/ friends round to the flat since we last spoke?

IF YES, How were these visits? How did you feel when they visited? (PROUD, ANXIOUS, PROTECTIVE OVER THE FLAT?)

IF NO, Are there any particular reasons for this? (PROBE FOR WHETHER ADVISED AGAINST THIS OR NOT ALLOWED VISITORS?)

Are there any friends you wouldn't invite round? IF YES, Could you tell me why?

How would you compare your sense of choice and freedom in a flat with when you were homeless?

Could you give me reasons for this?

Support/Treatment

How is your relationship with your case manager?

What kind of things have they been helping you with recently?

Have any problems arose in your relationship with your case manager?

Domains

Now I'd like to talk more specifically about different areas of your life which we identified in earlier interviews. These questions are open and so do not have set responses for you to choose from. Instead I'd like to invite you to talk more freely in your responses.

Education and Training

Have you been involved in any education or training since we last spoke?

IF YES, when did you start?

What were your reasons for getting involved? (PROBE FOR REASONS FOR ATTENDING - VOLUNTARY OR MANDATORY AND FOR WHETHER OWN CHOICE)

Have you been involved in any in any leisure activities or hobbies since we last spoke or would you like to be?

IF YES, When did you start?

What were your reasons for getting involved? (PROBE FOR REASONS FOR ATTENDING - VOLUNTARY OR MANDATORY AND WHETHER OWN CHOICE)

Employment and Volunteering

Have you been involved in any employment or volunteering since we last spoke?

Would you like to be involved in employment or volunteering in the future?

Do you see it as a possibility for you?

Income/Debt/ Benefits

Have your finances improved since we last spoke?

IF YES, Why have they improved? (PROBE FOR SUPPORT AND REDUCTION IN ANY COSTLY BEHAVIOURS)

IF NO, Why do you feel they haven't improved?

Did you receive any support during this period? Who did you receive support from? Was it useful?

IF IN RECEIPT OF BENEFITS, Have there been any periods when your benefits have been stopped?

Can you tell me why this happened?

What effect did this have on you? (PROBE FOR IMPACT ON SECURITY OF TENANCY, AND MENTAL HEALTH IMPACTS)

IF YES, Did you receive any support during this period?

Who did you receive support from? Was it useful?

Are there any conditions on your benefits you must follow? (PROBE FOR APPOINTMENTS, ACTIVITIES)

Has your benefits situation changed at all over the past 6 months? If so, how has it changed?

Health

How is your physical health currently? How would you compare your health now to six months ago? [IF CHANGE] what were the main reasons for this change?

Have you consciously tried to improve your health?

Has your change in living situation improved your health?

How is your mental health currently? How would you compare your mental health now to six months ago? [IF CHANGE] what were the main reasons for this change?

Have you experienced any issues of depression or anxiety in the last 6 months?

IF YES, Can you say why you felt this way? (PROBE FOR PROBLEMS RELATED TO MOVING INTO HOUSING FIRST)

[IF SELF HARM HISTORY] Have you had any instances of self harming in the past 6 months? What were the reasons for this?

IF DISABLED, Have there been any benefits or negative impacts on your disability since you moved in to your property? (PROBE FOR ISSUES WITH TRAVEL AND LOCATION)

Have you accessed any additional support for your disability over the past 6 months?

Drug and Alcohol

Do you currently use drugs? What type of drugs do you currently use?

Has your drug use changed at all over the last 6 months? [INCREASED/DECREASED or TYPE OF DRUG or SOCIAL/INDIVIDUAL]

How do you feel about managing your drug use currently? Has there been any changes with this?

Do you consider yourself to have a drug problem?

Why do you take drugs?

What is your current alcohol consumption ?

Has your alcohol consumption changed at all over the last 6 months?[INCREASED/DECREASED or TYPE OF ALCOHOL or SOCIAL/INDIVIDUAL]

How do you feel about managing you alcohol consumption currently? Has there been any changes with this?

Criminal behaviour/ convictions

Please note: if you tell me about any crime that is not yet known to the police, I will have to pass the information on – these questions are about any offence for which you have a criminal record.

[IF UNSPENT CONVICTIONS] Do you have any statutory orders/ are you on probation? How does this influence your day to day life?

Are there any conditions related to these statutory orders?

Have you committed any crimes over the past 6 months? [IF YES] Could you tell me about this? (PROBE FOR LOCATION, WHO WAS INVOLVED, WHICH KIND OF CRIME)

Why did you commit this crime?

Have you been a victim of crime in the past 6 months? [IF YES] Could you tell me about this? (PROBE FOR LOCATION, WHO WAS INVOLVED, WHICH KIND OF CRIME)

Street Culture Activities

Have you spent any nights away from your flat? IF YES, Where did you spend these?

Have you rough slept at any point over the past 6 months? IF YES, could you give me your reasons for this?

Have you engaged in any begging or street drinking over the past 6 months? IF YES, could you give me your reasons for this?

Quality of Life, Subjective Health and Subjective Wellbeing

I'd like cover the same general questions which we did at the start of our last interview. These questions will allow me to gather how you feel about your quality of life, health and sense of wellbeing. For each of these questions I will read out the question, the options for responding and ask you for your reasons for your response.

How would you rate your current quality of life?

1	2	3	4	5
Very Poor	Poor	Neither poor nor good	Good	Very good

Could you give me reasons for your response?

All things considered how satisfied are you with your life as a whole?

1 Very Dissatisfied	2 Dissatisfied	3 Neither dissatisfied nor satisfied	4 Satisfied	5 Very satisfied
------------------------	-------------------	---	----------------	---------------------

Could you give me reasons for your response?

How would you rate your current health?

1 Very Poor	2 Poor	3 Neither poor nor good	4 Good	5 Very Good
----------------	-----------	-------------------------------	-----------	----------------

Could you give me reasons for your response?

Social Trust Question

Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people? Please give a score of 0 to 10, where 0 means you can't be too careful and 10 means that most people can be trusted.

Can't be too careful 0	1	2	3	4	5	6	7	8	9	Most people can be trusted 10
-------------------------------------	---	---	---	---	---	---	---	---	---	---

Could you give me reasons for your response?

SWEMWBS (Short Warwick Edinburgh Mental Wellbeing Scale)

Now I'd like you to respond to some statements about feelings and thoughts. Please choose the answer that best describes your experience of each over the last two weeks.

Read out statement and repeat response options after each statement is read out.

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my mind about things					

Perception and level of choice

Pearlin and Schooler Mastery Scale

I'd now like to look at your level of mastery or control over your life. I have 7 questions, each of which I'd like you to answer on a four point scale from 'strongly agree' (1) to 'strongly disagree'(4).

Statements	1 ‘Strongly Agree’	2 ‘Agree’	3 ‘Disagree’	4 ‘Strongly Disagree’
There is really no way I can solve some of the problems I have				
Sometimes I feel that I'm pushed about in life				
I have little control over the things that happen to me				
RC - I can do just about anything I really set my mind to				
I often feel helpless in dealing the with problems of my life				
RC - What happens to me in the future mostly depends on me				
There is little I can do to change many of the important things in my life				

Outcome priorities

Explore respondent's outcome priorities – cover each and explore;

- whether they feel they have achieved them?
- whether they feel that they have moved towards them?
- If they have achieved or moved towards how and what/who has contributed?
- if they have not achieved or moved towards why and what/who has contributed?
- have they changed?

How far have you been able to guide your support towards these priorities?

Do you think you will achieve your goals?

What do you feel will stop your reaching your priorities/goals?

Participant Review

Use temporal maps for participant's time in HF and 'life history' to:

- Review for inaccuracies
- Validate key themes in each participant's time in HF and life history respectively
- Validate sequencing and ordering of events, needs, capabilities.

C.2.4: 'Life History' Interview – Client Participant Topic Guide

Client Participants – Personal History

Introduction

We would like you to take part in this piece of research because we want to find out as much as possible about the lives of the people involved in Housing First. We would be very grateful if we could talk to you for around one hour. You can end the interview at any time that you want to and can leave out any questions that you would prefer not to answer.

I would like to record the interview, but can make written notes if you would prefer me to. The recording will be written down by me at Northumbria University. Nothing will ever be said or written that would mean that you could be identified as someone who took part in the research. If you would like to see a written record of the interview once it has been produced, I can arrange for that to happen.

- *Explain Research and Aims via research information form.*
- *Ensure participant fully understands all information provided on research information form.*
- *Ask participant to sign 2 x consent form (1 x participant, 1 x researcher)*

Client's personal background and history of risk behaviours

Childhood

I'd like to talk now about your childhood, if that's okay. Please could you tell me about the place or places where you were born and grew up?
(PROBE FOR AS MUCH DETAIL AS POSSIBLE, TOWN/ESTATE)

Please could you tell me about your earliest memories?

Please could you tell me about the people that you grew up with? (TRY TO PROBE FOR FAMILY MEMBERS OR WHETHER TAKEN INTO CARE)

Did anyone you grew up with work? (TRY TO PROBE FOR WHO)

Did you think of yourself as being well off or badly off as you grew up? Please could you tell me why?

Please can you tell us about the house or houses that you grew up in? (PROBE FOR OWNER OCCUPIED/COUNCIL/PRIVATE RENTED/ETCETERA)

Were you ever forced to leave somewhere that you lived? (IF YES) Please could you tell me what happened?

Would you describe your childhood as happy? Why do you say that?

Education and Training

Did you get any qualifications through education or training? (IF YES) Please could you tell me what they are?

Can you tell me some of your memories of being at school?

Did you like school? (PROBE FOR WHY/WHY NOT)

Did you have any difficulties in reading and writing? [IF YES] Were you given any help with these difficulties?

Did you regularly attend school? (PROBE FOR TRUANCY AND SUSPENSION)

Were you bullied at school or did you bully other people? [IF YES TO EITHER] What happened as a result of this bullying?

Looking back, do you have any regrets about your time in school?

Did you go to college or university after school?

[IF WENT TO COLLEGE/UNIVERSITY] Why did you pick that course? What did you hope to do with the qualification after College/University?

Employment / Income / Debt

Please could you tell me about any jobs that you have had? (PROBE FOR FULL TIME / PART TIME AND TYPES OF JOB)

What job have you held for the longest time?

Did you enjoy working?

Have you had periods in your adult life when you weren't working? (PROBE FOR HOW LONG, AT WHAT AGE, ETCETERA)

Would you like to be working in the near future? If so, what type of job would you like to do?

Have you ever been involved in any voluntary work or would you like to be in the near future? If so, please could you tell me what type of voluntary work?

(FOR CLIENTS WHO HAVE BEEN IN A HOUSING FIRST PROPERTY FOR 3 MONTHS - PROBE FOR WHETHER VOLUNTARY WORK OR DESIRE FOR VOLUNTARY WORK HAPPENED AFTER ENTERING HOUSING FIRST)

Are you involved in any education or training now or would you like to be in the near future? If so, please could you tell me more about this?

(FOR CLIENTS WHO HAVE BEEN IN A HOUSING FIRST PROPERTY FOR 3 MONTHS - PROBE FOR WHETHER EMPLOYMENT OR DESIRE FOR EMPLOYMENT HAPPENED AFTER ENTERING HOUSING FIRST)

Have you experienced financial difficulties at any point in your adult life?

(IF YES) Please could you tell me what they were and when they occurred?

Do you have any financial difficulties which continue now?

(IF EXPERIENCED FINANCIAL DIFFICULTIES) Did you seek any help from anyone about financial difficulties? (IF YES) Please could you tell me who you sought help from? Were they helpful?

(FOR CLIENTS WHO HAVE BEEN IN A HOUSING FIRST PROPERTY FOR 3 MONTHS) Have you encountered any financial difficulties which have started since entering Housing First?

Marriage / Family / Social Networks

Have you ever been married or lived with anybody in a long term relationship?

(IF YES) Please can you tell me why your marriage(s) / long term relationship(s) broke down?

What impact did this have on you?

Do you have any children? (IF YES) How old are they? Who do they live with? Do you ever see them? How do you get on with your children?

Are you currently in a relationship?

IF YES How long have you been in this relationship for?

IF NO would you like to be in a relationship, either now or in the future? Why?

Social Support, Family and Friends

Who can you really count on to listen to you? (PROBE FOR WHETHER INFORMAL FAMILIAL SUPPORT OR PROFESSIONAL AND SITUATIONAL DIFFERENCES)

Who could you call on to help you in a crisis? (PROBE FOR WHETHER INFORMAL FAMILIAL SUPPORT OR PROFESSIONAL)

Do you have any family who would be willing to help you in a time of difficulty? (IF YES) Could you tell me who they are and what type of help they could provide you with?

Were you in contact with them before you entered HF? Has your relationship with them changed since entering HF?

Do you have any friends? (IF YES) Where do you know these friends from? How long have you been friends with them? Would your friends be willing to help you in a time of difficulty? IF YES could you tell me what type of help they could provide you with? Where do you spend most time with these friends?

Were you in contact with them before you entered HF? Has your relationship with them changed since entering HF?

(IF PEOPLE HAVE FRIENDS WHO ARE NOT HOMELESS) How often do you see your friends?

(FOR CLIENTS WHO HAVE BEEN IN A HOUSING FIRST PROPERTY FOR 3 MONTHS)

Have you made any new friends since entering Housing First? Where did you meet these friends?

Have you seen any friends you met before Housing First less since entering Housing First?

Have you seen any members of your family more or less since entering Housing First?

Why do you think you see them more now?

Marriage / Family / Social Networks

Have you ever been married or lived with anybody in a long term relationship?

What impact did this have on you?

IF YES How long have you been in this relationship for?

IF NO would you like to be in a relationship, either now or in the future? Why?

Housing History

Have you ever owned or rented a home before (INCLUDES JOINTLY WITH PARTNER)?

(IF YES) Please could you tell me, for each home you owned or rented, roughly how long you lived there?

Did you pay for the housing from wages or benefits or both?

Did you pay the bills and/or rent yourself?

Did you ever struggle to pay the bills/ and or rent? (PROBE ARREARS)

What happened to the last home which you owned or rented?

As an adult, were you ever forced to leave somewhere that you lived? (IF YES) Please could you tell me what happened?

Health/Disabilities

Do you have any disabilities or long term health conditions? (IF YES) Could you tell me about it/them? What impact did this have/has this had on your life? (EG UNABLE TO WORK)

Have you ever had any periods of illness? (IF YES) Please could you tell me what the illness was? How long did it last? What was the impact (EG LOSS OF WORK)?

Has/Do you see being in independent housing had any impact on your disability/long term health condition?

Who would you go to if you had an illness or other health problem?

Mental Health

(IF NOT ALREADY DISCUSSED) Do you consider that you suffer, or have suffered in the past, from any mental health difficulty such as depression? Please could you tell me what impact this difficulty has or had on you?

(IF YES) How long have you suffered from this issue?

(IF NO) How did this issue affect you (PROBE VARIABLE SEVERITY OF EFFECTS OVER LIFE COURSE)

Have you ever been formally diagnosed with a mental health disorder?

(IF YES) Could you tell me what that disorder is? Could you tell me who diagnosed you?

Drugs / Alcohol

Drug and Alcohol

Past Drug and Alcohol use

Has drug-use ever been a problem for you?

If yes, what drugs did you use (PRESCRIPTION/ILLEGAL DRUGS, NAME OF DRUGS)

At what age did drug use become a problem for you?

What happened as a result of your drug problem? Did you receive any help for your drug problem? (IF YES) Was this help useful to you?

Do you consider yourself to have a drug problem now?

Do you currently drink alcohol or have you ever drunk alcohol in the past?

(IF YES)...

At what age did you first drink alcohol?

Has alcohol use ever been a problem for you? (IF YES) At that time, how much alcohol would you say that you drank in a typical week? What happened as a result of your alcohol problem? Did you receive any help for your alcohol problem? (IF YES) Was this help useful to you?

Do you consider that you have an alcohol problem now?

(FOR CLIENTS WHO HAVE BEEN IN A HOUSING FIRST PROPERTY FOR 3 MONTHS)

Has your drug use changed since entering Housing First? (PROBE FOR CHANGE IN TYPE OF DRUG, QUANTITY AND WHEN AND WHERE DRUG USE TAKES PLACE)

Have you received any additional support for your drug use since entering Housing First?

Has your alcohol use changed since entering Housing First? (PROBE FOR CHANGE IN TYPE OF ALCOHOL, QUANTITY AND WHEN AND WHERE ALCOHOL USE TAKES PLACE)

Crime / Institutionalisation

Please note: if you tell me about any crime that is not yet known to the police, I will have to pass the information on – these questions are about any offence for which you have a criminal record.

Do you have a criminal record? (IF YES) Please could you tell me which offences you have your criminal record for and when they occurred? Please could you tell me why you committed the offences? Did you receive any help for your offending?

Have you ever been to prison? (IF YES) How long for? Please could you tell me what it was like in prison? What happened to you when you came out of prison? Did you receive help from anybody when you came out of prison? What impact did going to prison have on your life?

Have you ever been a victim of crime? (IF YES) Please could you tell me about this and the impact that it had on you?

Do you still currently hold any statutory orders? Are you on probation? Are there any other impacts of your criminal records which impact your current situation/day to day life?

(FOR CLIENTS WHO HAVE BEEN IN A HOUSING FIRST PROPERTY FOR 3 MONTHS)

Did there offences take place before you entered Housing First?

Have you committed any offences since entering Housing First?

Have you been a victim of crime since entering Housing First?

History of homelessness

When did you first experience rough sleeping? How old were you?

Which factors led to you ending up homeless/ rough sleeping in the first instance?

What was your living situation before this first spell of rough sleeping? (if homeless: stayed with friends?/ applied to council?)

[IF HOMELESS] Have you been homeless on any other occasions? How many times? Could you describe your living situation at each of these points?

How did you feel about being homeless?

Please could you tell me what happened after you became homeless?

C.3: Stakeholder Participant Topic Guides

C.3.1: Wave 1 – Case/Service Manager Topic Guides

Introduction

We would like you to take part in this piece of research because we want to find out as much as possible about the lives of the people involved in Housing First. We would be very grateful if we could talk to you for around one hour. You can end the interview at any time that you want to and can leave out any questions that you would prefer not to answer.

I would like to record the interview, but can make written notes if you would prefer me to. The recording will be written down by me at Northumbria University. Nothing will ever be said or written that would mean that you could be identified as someone who took part in the research. If you would like to see a written record of the interview once it has been produced, I can arrange for that to happen.

- *Explain Research and Aims via research information form.*
- *Ensure participant fully understands all information provided on research information form.*
- *Ask participant to sign 2 x consent form (1 x participant, 1 x researcher)*

About the worker

Could you give your name, the organisation you work for and your role in the organisation?

What is your role in relation to the clients of Housing First?

(IF IN ME TEAM) do you work specifically with Housing First clients?

Philosophy of Housing First

To get some context i'd like to chat about Housing First as an overall model or philosophy first...

What does HF mean to you?

What do you do differently between a Housing First client and a PRS client?

Are you aware of other Housing First services around the world?

Could you tell me which services/countries are you aware of?

Are there any of these services which you feel are similar to the service in Newcastle? (PROBE FOR WHICH IS MOST SIMILAR)

Is there anything which makes the Housing First service/ ME service unique/different in Newcastle?

If so, what influences this difference? (PROBE FOR VARIATIONS FROM HOUSING FIRST PHILOSOPHY OR WORKING PRACTICES IN NEWCASTLE)

About Housing First Newcastle

In your opinion, what is the purpose of the Housing First service in Newcastle upon Tyne?

Who is the service designed for? Why was it designed for these individuals?

Has the service changed since it was funded through the council rather than the Homeless Transition Fund?

If so, how has it changed?

How does Housing First fit with the rest of the response to homelessness in Newcastle?

Referrals, Recruitment and Readiness

(IF NOT ALREADY STATED) Who are the target group for this service?

How flexible are you with this entry criteria?

I'd like to discuss the referral pathway for the Housing First service.

How were the current clients of Housing First referred to the service? Is there more than one referral route which clients come through?

Who are they referred to? (SPECIFIC PERSON OR SERVICE IN GENERAL)

Did the referral pathway change after the council began funding the service?

(IF YES) How did it change?

Once an individual is referred to Housing First how do you make contact with them? (PROBE FOR DETAILS OF FIRST MEETING)

How do you ensure someone is suitable for Housing First? (PROBE FOR REFERRAL OR WRITTEN CRITERIA)

Are there any reasons you wouldn't take a client into Housing First?

Are there any reasons why you may need to delay a client entering Housing First?

(IF YES) Could you tell me about these reasons?

Are you aware of any specific cases where individuals have been referred and refused access to Housing First? If so, could you tell me about them?

Are there any issues or challenges with the current referral pathway?

(IF YES) Could you tell me about these challenges?

Past experience

Before we go into how you work with clients I'd just like to briefly ask you some questions about your own background, if that's okay?

Have you previously experienced homelessness or any of the other issues clients are facing?
(PROBE WHICH ISSUES)

(IF YES) Does this positively influence the way you work with clients?

Are there any negative impacts on how you work with clients?

Working with clients – managing cases

How many clients do you currently work with? Is this the average between all case managers?

Do you feel that this workload is appropriate? (PROBE FOR MORE OR LESS)

What are your reasons for this? (CASE OF PURE NUMBERS OR INTENSITY OF SUPPORT REQUIRED)

How much time do you spend with each client on a weekly basis? How do you decide this? (time constraints/ planned/ chosen by client?)

Do you feel like you spend enough time with each client?

Are there any particular approaches you use when working with clients?

(IF YES) Does this differ between clients?

What are the advantages of these approaches?

Are there any disadvantages of these approaches?

First steps/ working with clients

How do you allocate which clients work with which support worker?

Are clients of Housing First generally 'new' to the multiple exclusion team or have relationships already been established?

What does the first meeting/ contact usually entail? (PROBE FOR NEEDS ASSESSMENTS)

Where does this contact take place? How is this decided?

Balancing outcomes

When a client has been accepted into Housing First what are usually the initial priorities? (IF NOT NOTED AS ABOUT finding and moving into housing, organizing finances, and addressing immediate mental health and physical health needs. Longer-term needs of HFE participants include assisting individuals with vocational planning, participation in meaningful community activities, and social isolation.)

What kind of goals do you have for clients when they enter their property?

How are these priorities decided? Are they the same for all clients or do you differ?

If they do differ, why is this the case?

When looking at the areas to work on with clients do you consider the outcomes defined in the service contract?

Are there ever any tensions between the contract outcomes and client's own outcome priorities?

What about your own goals and a client's priorities?

(IF YES) What kind of tensions have you come across? (PROBE FOR SPECIFIC EXAMPLES) Do these tensions cause any other issues?

(IF NO) What reasons do you think there are for there being a lack of tensions?

What kind of outcomes are the most difficult to reach with clients? (PROBE MH, SM, HOUSING, MA, SR)

Acquiring Housing (more for Service Managers)

Is finding housing the first step in the Housing First service in Newcastle?

Do you work closely with specific landlords to find housing?

(IF YES) Do you have a special agreement with these landlords?

Do these landlords specialise in tenants on housing benefit?

Were/are there any specific concerns which landlords have when discussing taking tenants through Housing First?

Are clients set up as tenants in their own right? (AS OPPOSED TO SUBLET)

What proportion of the client's personal budget goes to accommodation?

Are clients subsidised by the project in terms of rent or are all costs bore by the client themselves?

To what extent are client's priorities included in finding and acquiring housing? (PROBE FOR LOCATION, HOUSING TYPE, NUMBER OF BEDROOMS ETC.)

Are there any recurring priorities amongst clients around housing? (PROBE FOR LOCATION, FURNISHINGS, TYPE, TENURE)

Are client's able to view their new housing before agreeing to it?

How many housing options do clients have to choose from?

Does this change from client to client? (IF YES) Could you tell me about the reasons for this?

What limitations are there on client's priorities when trying to find housing?

What are the main challenges in acquiring housing for clients?

Are there any particular challenges associated to finding housing in Newcastle? (PROBE FOR PROPERTY MARKET ISSUES, PRS ONLY STIPULATION)

'Separation of Housing and Support' / Autonomy over behaviour

How much autonomy do clients have over how they behave when in their own home?

Are there any stipulations/restrictions clients need to follow when in Housing First?

What is the procedure if clients break any stipulations? (PROBE FOR COMMITMENT TO WORK WITH CLIENTS FOR AS LONG AS REQUIRED)

Have you had many cases of clients

Are there any external stipulations which may impact on client's ability to exercise full control and autonomy? (PROBE FOR WELFARE REFORM, SANCTIONS AND REQUIREMENTS OF OTHER SERVICES)

Transition

Are there any characteristics or factors you've noticed which allow some clients to settle better than others?

Why do you think many Housing First clients were in homeless situations for so long?

Why do you think they were so often evicted from hostel accommodation?

For the clients you work with what are the main differences between being in hostels/on streets and being in their own flat?

What is it about these differences which influences their actions?

Are these true for all clients?

Have you noticed any difference in the way clients make choices in Housing First?

Do clients still make instinctive choices about their daily routine in their own property?

Have you seen any change in client's actions since they've moved into their own flat? (substance misuse, offending, routine)

Why do you think these actions have changed?

Do you feel that clients have more to lose in their own property or in hostels?

Why do you feel that way?

Challenges

What are the main challenges clients face when first moving into their property?

How do they overcome these challenges? How do you support them to do so?

Do these challenges change over time?

How are decisions made around which support or activities clients need and access?

Who generally brings this up?

How do you know how to differ the type and level of support between different clients?

How often do clients refuse the support you discuss with them or offer to them?

Do you think client's feel free to say no to offers of support?

Do you include client's priorities when looking at which support they access or receive?

How do you include these priorities? (PROBE FOR CLIENT BASED EXAMPLES)

Do client's priorities change in terms of their goals and what they want from the service over time?

(IF YES) Do they change regularly? (PROBE FOR HOW OFTEN)

How do clients of Housing First differ in terms of support needs?

Are there any particular needs or characteristics (or a combination of these) which present particular challenges for a Housing First service?

If so, could you explain more? Could you give me an example of where a client's needs or characteristics have presented challenges for a Housing First service?

Working with other organisations

Do you include other organisations in clients support?

How do you decide which organisations to involve?

Are there ever any tensions with the working practices of other organisations and the philosophy of this Housing First service? (E.G. ABSTINENCE)

Progression/ Success

Have you seen progression in clients?

What do you attribute the progression to most?

In your opinion has Housing First service been a success?

Why do you feel this way?

Open ended support

Do you have an 'end point' for clients?

(IF YES) What would you do at this point?

How do you know clients are ready to end support?

Do clients maintain their housing even if they stop receiving support from yourselves?

If a client is evicted from their Housing First apartment do you continue to work with them?

Is it difficult to acquire housing for clients after a PRS eviction?

C.3.2: Wave 3 – Case/ Service Manager Topic Guides

Introduction

We would like you to take part in this piece of research because we want to find out as much as possible about the lives of the people involved in Housing First. We would be very grateful if we could talk to you for around one hour. You can end the interview at any time that you want to and can leave out any questions that you would prefer not to answer.

I would like to record the interview, but can make written notes if you would prefer me to. The recording will be written down by me at Northumbria University. Nothing will ever be said or written that would mean that you could be identified as someone who took part in the research. If you would like to see a written record of the interview once it has been produced, I can arrange for that to happen.

- *Explain Research and Aims via research information form.*
- *Ensure participant fully understands all information provided on research information form.*
- *Ask participant to sign 2 x consent form (1 x participant, 1 x researcher)*

About the worker

Could you give your name, the organisation you work for and your role in the organisation?

What is your role in relation to the clients of Housing First?

(IF IN ME TEAM) do you work specifically with Housing First clients?

Philosophy of Housing First

To get some context i'd like to chat about Housing First as an overall model or philosophy first...

What does HF mean to you?

What do you do differently between a Housing First client and a PRS client?

Are you aware of other Housing First services around the world?

Could you tell me which services/countries are you aware of?

Are there any of these services which you feel are similar to the service in Newcastle? (PROBE FOR WHICH IS MOST SIMILAR)

Is there anything which makes the Housing First service/ ME service unique/different in Newcastle?

If so, what influences this difference? (PROBE FOR VARIATIONS FROM HOUSING FIRST PHILOSOPHY OR WORKING PRACTICES IN NEWCASTLE)

About Housing First Newcastle

In your opinion, what is the purpose of the Housing First service in Newcastle upon Tyne?

Who is the service designed for? Why was it designed for these individuals?

Has the service changed since it was funded through the council rather than the Homeless Transition Fund?

If so, how has it changed?

How does Housing First fit with the rest of the response to homelessness in Newcastle?

Past experience

Before we go into how you work with clients I'd just like to briefly ask you some questions about your own background, if that's okay?

Have you previously experienced homelessness or any of the other issues clients are facing? (PROBE WHICH ISSUES)

(IF YES) Does this positively influence the way you work with clients?

Are there any negative impacts on how you work with clients?

Working with clients – managing cases

How many clients do you currently work with? Is this the average between all case managers?

Do you feel that this workload is appropriate? (PROBE FOR MORE OR LESS)

What are your reasons for this? (CASE OF PURE NUMBERS OR INTENSITY OF SUPPORT REQUIRED)

How much time do you spend with each client on a weekly basis? How do you decide this? (time constraints/ planned/ chosen by client?)

Do you feel like you spend enough time with each client?

Are there any particular approaches you use when working with clients?

(IF YES) Does this differ between clients?

What are the advantages of these approaches?

Are there any disadvantages of these approaches?

Balancing outcomes – Power relations

What does success mean for clients in Housing First?

When a client has been accepted into Housing First what are usually the initial priorities? (IF NOT NOTED AS ABOUT finding and moving into housing, organizing finances, and addressing immediate mental health and physical health needs. Longer-term needs of HFE participants include assisting individuals with vocational planning, participation in meaningful community activities, and social isolation.)

What kind of goals do you have for clients when they enter their property?

How are these priorities decided? Are they the same for all clients or do you differ?

If they do differ, why is this the case?

When looking at the areas to work on with clients do you consider the outcomes defined in the service contract?

Are there ever any tensions between the contract outcomes and client's own outcome priorities?

What about your own goals and a client's priorities?

(IF YES) What kind of tensions have you come across? (PROBE FOR SPECIFIC EXAMPLES) Do these tensions cause any other issues?

(IF NO) What reasons do you think there are for there being a lack of tensions?

What kind of outcomes are the most difficult to reach with clients? (PROBE MH, SM, HOUSING, MA, SR)

Who do you think has more power in the relationship between you and the client?

And what about the relationship between client and landlord?

Acquiring Housing (more for Service Managers)

Is finding housing the first step in the Housing First service in Newcastle?

Do you work closely with specific landlords to find housing?

(IF YES) Do you have a special agreement with these landlords?

Do these landlords specialise in tenants on housing benefit?

Were/are there any specific concerns which landlords have when discussing taking tenants through Housing First?

Are clients set up as tenants in their own right? (AS OPPOSED TO SUBLET)

What proportion of the client's personal budget goes to accommodation?

Are clients subsidised by the project in terms of rent or are all costs bore by the client themselves?

To what extent are client's priorities included in finding and acquiring housing? (PROBE FOR LOCATION, HOUSING TYPE, NUMBER OF BEDROOMS ETC.)

Are there any recurring priorities amongst clients around housing? (PROBE FOR LOCATION, FURNISHINGS, TYPE, TENURE)

Are client's able to view their new housing before agreeing to it?

How many housing options do clients have to choose from?

Does this change from client to client? (IF YES) Could you tell me about the reasons for this?

What limitations are there on client's priorities when trying to find housing?

What are the main challenges in acquiring housing for clients?

Are there any particular challenges associated to finding housing in Newcastle? (PROBE FOR PROPERTY MARKET ISSUES, PRS ONLY STIPULATION)

'Separation of Housing and Support' / Autonomy over behaviour

How much autonomy do clients have over how they behave when in their own home?

Are there any stipulations/restrictions clients need to follow when in Housing First?

What is the procedure if clients break any stipulations? (PROBE FOR COMMITMENT TO WORK WITH CLIENTS FOR AS LONG AS REQUIRED)

Have you had many cases of clients

Are there any external stipulations which may impact on client's ability to exercise full control and autonomy? (PROBE FOR WELFARE REFORM, SANCTIONS AND REQUIREMENTS OF OTHER SERVICES)

Transition

Are there any characteristics or factors you've noticed which allow some clients to settle better than others?

Why do you think many Housing First clients were in homeless situations for so long?

Why do you think they were so often evicted from hostel accommodation?

For the clients you work with what are the main differences between being in hostels/on streets and being in their own flat?

What is it about these differences which influences their actions?

Are these true for all clients?

Have you noticed any difference in the way clients make choices in Housing First?

Do clients still make instinctive choices about their daily routine in their own property?

Have you seen any change in client's actions since they've moved into their own flat? (substance misuse, offending, routine)

Why do you think these actions have changed?

Do you feel that clients have more to loose in their own property or in hostels?

Why do you feel that way?

Challenges

What are the main challenges clients face in Housing First?

How do they overcome these challenges? How do you support them to do so?

Do these challenges change over time?

How are decisions made around which support or activities clients need and access?

Who generally brings this up?

How do you know how to differ the type and level of support between different clients?

How often do clients refuse the support you discuss with them or offer to them?

Do you think client's feel free to say no to offers of support?

Do you include client's priorities when looking at which support they access or receive?

How do you include these priorities? (PROBE FOR CLIENT BASED EXAMPLES)

How do clients of Housing First differ in terms of support needs?

Are there any particular needs or characteristics (or a combination of these) which present particular challenges for a Housing First service?

If so, could you explain more? Could you give me an example of where a client's needs or characteristics have presented challenges for a Housing First service?

Working with other organisations

Do you include other organisations in clients support?

How do you decide which organisations to involve?

Are there ever any tensions with the working practices of other organisations and the philosophy of this Housing First service? (E.G. ABSTINENCE)

Progression/ Success

Have you seen progression in clients?

What do you attribute the progression to most?

In your opinion has Housing First service been a success?

Why do you feel this way?

Open ended support

Do you have an 'end point' for clients?

(IF YES) What would you do at this point?

How do you know clients are ready to end support?

Do clients maintain their housing even if they stop receiving support from yourselves?

If a client is evicted from their Housing First apartment do you continue to work with them?

C.3.3: Wave 3 - Commissioner Topic Guide

Introduction

We would like you to take part in this piece of research because we want to find out as much as possible about the lives of the people involved in Housing First. We would be very grateful if we could talk to you for around one hour. You can end the interview at any time that you want to and can leave out any questions that you would prefer not to answer.

I would like to record the interview, but can make written notes if you would prefer me to. The recording will be written down by me at Northumbria University. Nothing will ever be said or written that would mean that you could be identified as someone who took part in the research. If you would like to see a written record of the interview once it has been produced, I can arrange for that to happen.

- *Explain Research and Aims via research information form.*
- *Ensure participant fully understands all information provided on research information form.*
- *Ask participant to sign 2 x consent form (1 x participant, 1 x researcher)*

About the worker

Could you give your name, the organisation you work for and your role in the organisation?

What is your role in relation to the clients of Housing First?

(IF IN ME TEAM) do you work specifically with Housing First clients?

Philosophy of Housing First

To get some context i'd like to chat about Housing First as an overall model or philosophy first...

What does HF mean to you?

What do you think should be done differently between a Housing First client and a PRS client?

Are you aware of other Housing First services around the world?

Could you tell me which services/countries are you aware of?

Are there any of these services which you feel are similar to the service in Newcastle? (PROBE FOR WHICH IS MOST SIMILAR)

Is there anything which makes the Housing First service/ ME service unique/different in Newcastle?

If so, what influences this difference? (PROBE FOR VARIATIONS FROM HOUSING FIRST PHILOSOPHY OR WORKING PRACTICES IN NEWCASTLE)

About Housing First Newcastle

In your opinion, what is the purpose of the Housing First service in Newcastle upon Tyne?

Who is the service designed for? Why was it designed for these individuals?

Has the service changed since it was funded through the council rather than the Homeless Transition Fund?

If so, how has it changed?

How does Housing First fit with the rest of the response to homelessness in Newcastle?

Referrals

How was it decided which clients would access the Housing First service?

Was there a specific criteria for clients?

Who was involved in this discussion?

Who, ultimately had the final say in who accessed the service?

Hopes for the service

What were your hopes when you set up the service?

Did you expect any clients to lose their tenancy and end up back in a homeless situation?

Transition

Why do you think many Housing First clients were in homeless situations for so long?

Why do you think they were so often evicted from hostel accommodation?

Have you seen any change in client's actions since they've moved into their own flat? (substance misuse, offending, routine)

Why do you think these actions have changed?

Do you feel that clients have more to lose in their own property or in hostels?

Why do you feel that way?

Housing

Why did the service centre on PRS allocated housing?

Why was the requirement put forward that housing should only be sourced in the Newcastle area?

Moving forward, do you feel that sourcing housing outside of the Newcastle area would be appropriate?

Balancing outcomes – Power relations

What does success mean for clients in Housing First?

How were the outcomes stipulated in the contract decided upon?

When a client has been accepted into Housing First what do you think should be the initial priorities? (IF NOT NOTED AS ABOUT finding and moving into housing, organizing finances, and addressing immediate mental health and physical health needs. Longer-term needs of HFE participants include assisting individuals with vocational planning, participation in meaningful community activities, and social isolation.)

What kind of goals do you have for clients when they enter their property?

(IF YES) What kind of tensions have you come across between the service priorities and the council's? (PROBE FOR SPECIFIC EXAMPLES) Do these tensions cause any other issues?

(IF NO) What reasons do you think there are for there being a lack of tensions?

What kind of outcomes are the most difficult to reach with clients? (PROBE MH, SM, HOUSING, MA, SR)

Who do you think has more power in the relationship between you and the client?

And what about the relationship between client and landlord?

Success?

Do you think the Housing First service has been a success in Newcastle?

If so, why?

If no, why not?

How have you measured success in the service?

Was this based on a client by client basis or on general outcome measures?

Challenges

What have been the main challenges for the Housing First service?

Did these challenges change over time?

Were you able to overcome any of these challenges?

How do you include these priorities? (PROBE FOR CLIENT BASED EXAMPLES)

How do clients of Housing First differ in terms of support needs?

Are there any particular needs or characteristics (or a combination of these) which present particular challenges for a Housing First service?

If so, could you explain more? Could you give me an example of where a client's needs or characteristics have presented challenges for a Housing First service?

Working with other organisations

How did you foresee external organisations being involved in service delivery?

Are there any forums or frameworks already in place which enable multi disciplinary working?

Are you aware of any challenges which emerged around multi-disciplinary working?

Could you tell me about the nature of these challenges?

Were you able to overcome any of these challenges?

Are there ever any tensions with the working practices of other organisations and the philosophy of this Housing First service? (E.G. ABSTINENCE)

Progression/ Success

Have you seen progression in clients?

What do you attribute the progression to most?

In your opinion has Housing First service been a success?

Why do you feel this way?

Open ended support

Does the service have an 'end point' for clients?

(IF YES) What would you do at this point?

How do you know clients are ready to end support?

If a client is evicted from their Housing First apartment should the service continue to work with them?

Is it difficult to acquire housing for clients after a PRS eviction?

Next Steps

What are the council's future plans for working with individuals with M&C needs?

How do they differ from the current Housing First model?

What are the similarities with the current HF model?

What kind of housing solutions will the council be seeking for these individuals?

What kind of staffing model will the council be utilising?

What kind of service philosophy or approach will the council be utilising?